

## **FINANCIAL POLICY**

1. All co-pay / co-insurance amounts are due at each visit or procedure.
2. Charges not covered by insurance are due at the time of service.
3. Balances remaining after insurance payment, are due within 30 days.
4. Any unpaid balance after 90 days will be charged an interest rate of 1.5 % per month until the account is paid in full.
5. We accept cash, check, Visa, Mastercard and Discover.
6. There is a returned check fee of \$35.00 for any checks returned without payment from your bank.

## **Maternity Care / Surgery**

1. Insurance benefits for maternity / surgery will be verified through your insurance carrier. For maternity, monthly payments will be established through the months of your prenatal care, so that your out-of-pocket expenses are credited two months prior to your due date.
2. For surgery, a prepay deposit may be requested, depending upon your out-of-pocket expenses as quoted by your insurance carrier.

## **Collection Accounts**

- 1. If you allow your account to go to collection, you are notifying our office that you are terminating the doctor / patient relationship.**
2. If your account has been sent to collection, after paying the entire balance plus collection fees, you will be on a PAYMENT AT TIME OF SERVICE for one year. You then will be permitted to return to a normal pay structure.
3. If your account has been sent to collection TWICE, you may return to our office after clearing your collection balance and fees. You will be put on a permanent PAYMENT AT TIME OF SERVICE basis.
4. Accounts are sent to collection starting at 90 days unless payment arrangements have been made. You will be responsible for all collection expenses charged to our office by any agency.

I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY CHARGES THAT ARE NOT COVERED BY MY INSURANCE. PAYMENT IS EXPECTED AT THE TIME OF MY VISIT. IF THIS CAN NOT BE DONE, I AGREE TO MAKE OTHER ARRANGEMENTS WITH THE BILLING DEPARTMENT. I ALSO AGREE TO PAY ANY FEES FROM ANY PAST DUE AMOUNTS.

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Patient:

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Date: