

PAYMENT POLICY

There are two forms of payment:

CASH-Every time you come in. After 60 days of non-payment, a \$25 late fee will be added to your account to be compounded monthly.

OR

INSURANCE ASSIGNMENT-Co-pay, insurance reimbursement signed to our clinic, (as explained below).

PLEASE CHECK HOW YOU WISH TO PAY: CASH Check CREDIT CARD

INSURANCE ASSIGNMENT PROGRAM

It is our desire to assist our patients whenever possible. The following insurance assignment program allows you, our patient, to receive the care you need without undue financial strain.

1. Waiting for insurance payment is a courtesy provided by this clinic. We reserve the right to withdraw this courtesy. We will bill your insurance company and accept assignment of benefits during your initial intensive care. Direct assignment will be discontinued when you have finished initial intensive care and a supportive health care program is recommended. We will notify you of the change.
2. You are responsible for your charges at time of service until your deductible has been met. Once your deductible has been met, you will be responsible for your co pay. This must be paid at time of service or at least weekly, and may be prepaid.
3. The insurance carriers are billed weekly. It is your responsibility to supply this office with necessary forms to complete billing if needed.
4. If you receive payment from your insurance carrier during the period which the clinic has accepted assignment of benefits, you are responsible to bring the check into this office within three days of receipt and endorse it over to the clinic. Failure to do this may result in collection action.
5. In the event this account is turned over to a professional collection agency, a \$50.00 service fee will be added to the account balance.
6. If you discontinue your care for any reason other than discharge by the doctor, you will be responsible for any unpaid balance, regardless of any claims submitted to your insurance company, at the time you discontinue care.
7. This clinic does not promise that an insurance company will pay. In the event that the insurance company disputes or rejects that claim, it will be the patient's responsibility to pay all the charges and pursue reimbursement from the insurance company on his/her own.

I have read the above provisions and wish to participate in the insurance assignment program. I hereby agree to abide by the provisions as specified above.

Patient's Signature

Date