

# ACKNOWLEDGEMENT OF FINANCIAL POLICY AND PATIENT CONSENT TO TREATMENT

**\*PLEASE INITIAL TO THE LEFT OF EACH STATEMENT**

\_\_\_\_\_ I understand that payment is due at the time services are rendered unless my physician contracts my insurance. All charges not covered by an approved insurance carrier remain my immediate responsibility. If my insurance is contracted I understand that the office will submit all of my claims to them.

\_\_\_\_\_ I understand that I am responsible for knowing my copays and have to make any copayments and unmet deductibles at the time of service.

\_\_\_\_\_ I understand that if I am a Medicare recipient, I am responsible for my deductible and 20%.

\_\_\_\_\_ I understand that the preferred method of payments is Cash or Check if authorized.

\_\_\_\_\_ I understand that a \$25 service charge is made for all returned checks and that once a check is returned I will need to pay with or cash for future services.

\_\_\_\_\_ I understand that in order for insurance claims to be submitted effectively and in a timely manner that I provide a copy of my current insurance card. If claims are rejected because improper information was given to the office, they are my responsibility.

If any diagnostic studies such as lab tests, x-rays, ultrasounds, and other ancillary services are required to complete your care, please be aware that these charges are billed directly to you from the facility rendering the care. This is separate from the office charges and may constitute an additional expense for which our office is not responsible.

Insurance is a contract between you and your insurance company. We are not a party to this contract. You are responsible for the timely payment of your account.

I hereby authorize my physician and related health care staff to provide medical services to me, and hereby consent to the performance of laboratory tests, diagnostic procedures, and other medical treatment as discussed with my physician.

All information that has been provided pertaining to my account is accurate and true to the best of my knowledge.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Print Name: \_\_\_\_\_