FINANCIAL POLICY

We are committed to meeting your health care needs. Our goal is to keep your insurance or other financial arrangements as simple as possible. In order to accomplish this in a cost-effective manner, we ask that you adhere to the following guidelines.

1. Payment is expected at time of service

2. We will file your insurance for you if we are a participating provider of your plan. You will be responsible for any and all services in excess of your insurance limits as well as all non-covered services.

3. All co-payments are due at the time of service.

4. If we are not participating providers of your plan, full payment is due at the time of service, unless prior arrangements have been made. We will give you complete forms that will be accepted by your insurance company for reimbursement.

We will mail to you a monthly billing statement for any outstanding balances.

I acknowledge that I understand and accept this financial policy.

__________________________________ __________________________

Signature Date