Name of Practice
Practice Address
Practice Phone Number

FINANCIAL POLICY

Thank you for choosing the XXXXXXXXXX as your healthcare provider. We are committed to providing the best medical care possible. Please understand that payment of your bill is considered a part of your treatment. The following statement explains our Financial Policy which we ask you to read, sing and return to us prior to your treatment.

- All patients should provide accurate and complete personal and insurance information prior to being seen by the doctor.
- All applicable co-pays, personal balances, both current and prior, are due at time of service.
- We accept cash, check or credit cards XXXXXXXXXXX.

Regarding Insurance

We participate in [list plans your group participates with]. For some other insurance we accept assignment of benefits but in all cases we require that the guarantor, the person who is financially responsible, is *personally* liable for all balance not covered by insurance. It is your responsibility to understand and comply with any predetermination of benefits or referral requirements. Please be aware that some, and perhaps all, of the services provided may be non-covered services or may not be considered medically necessary under the Medicare Program or by other medical insurance companies.

Usual and Customary Rates

We are committed to providing the best treatment for our patients and we charge what we believe to be reasonable and customary fees for our region and specialty. If your insurance company uses a different fee schedule, you will be responsible for any balance remaining.

Missed Appointments

Unless canceled at least 24 hours in advance, our policy to charge $xxx for a missed appointment. Please help us to serve you better by keeping scheduled appointments. This fee is not covered by insurance so it will be your personal responsibility.

Past Due Accounts

Overdue accounts will be referred to a collection agency. Legal fees that we pay to secure past due balances will be added to your account.

Co-Pay Balances

Payment for co-pays are expected at time of service. If co-pay balances are not paid on date of service a $XX.xx fee will be charged to your account. This fee is *not* covered by insurance so it will be your personal responsibility.

Returned Checks

For checks returned to us as unpaid by your bank, we will charge a $xxx..xx fee.

Please contact our Billing Office if you have any questions or concerns at (716) xxx-xxxx.

I have read the Financial Policy. I understand and agree to the Financial Policy.
☐ You have authorization to charge my credit care for any current or past due personal balance)s) upon receiving my verbal or written permission.

Print Name	Signature	Date