FINANCIAL POLICY

1. It is your responsibility to present your insurance ID card and photo ID at the time of your visit. In accordance with your insurance company's member handbook, it is your responsibility to provide accurate insurance information.
2. If you do not have an insurance or do not present a valid insurance card, you will be responsible for payment if valid insurances aren't provided within 15 days of service/ being notified
3. If your insurance plan requires a referral, it is your responsibility to obtain this prior to being seen by our physicians. If this referral is not obtained and your claim is denied the unpaid balance will be your financial responsibility.
4. All co-payments are due at the time of visit. Post-dated checks are no accepted.
5. The fee for a returned check is $ 25.
6. You are ultimately responsible for payment of charges for services you receive.
7. Cancellations for any scheduled appointment or procedure must be received in at least 24 hrs. prior to the scheduled appointment. Patients who fail to keep and or cancel a scheduled appointment may be charged a $25 No show fee
8. Medical record requests must be received in writing and at least 3 business days or 72 hours, whichever is greater, prior to the date needed. No fee will be charged to a patient requesting their medical record for the first time. Any additional requests made after the initial one will be subject to the fee according to the State of Ohio law. Fees must be received prior to record delivery. Medical records will be mailed to the authorized address. An official records release form must be signed by the patient prior to the release of records.
9. Codes and coverages change frequently and the doctors use best efforts to stay up to date on billing requirements. For proper malpractice coverage, we will bill codes for all services rendered.

Patient's Name: (print) _____

Patient's/ Guardians' Signature _____

Date: _____/_____`

LEGAL NOTICE/DISCLAIMER

The information contained in this document does not establish a standard of care, nor does it constitute legal advice. The information is for general informational purposes only and is written

from a risk management perspective to aid in reducing professional liability exposure. Please review this document for applicability to your specific practice. You are encouraged to consult with your personal attorney for legal advice, as specific legal requirements may vary from state to state.

Patient Financial Policy

Your understanding of our financial policies is an essential element of your care and treatment. If you have any questions, please discuss them with our front office staff or supervisor.

- As our patient, you are responsible for all authorizations/referrals needed to seek treatment in this office.
- Unless other arrangements have been made in advance by you, or your health insurance carrier, payment for office services are due at the time of service. We will accept VISA, MasterCard, Discover, cash or check.
- Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor. In other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment.
- We have made prior arrangements with certain insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay the co-pay/co-insurance/deductible.
- If you have insurance coverage with a plan with which we do not have a prior agreement, we will prepare and send the claim for you on an unassigned basis. This means your insurer will send the payment directly to you. Therefore, all charges for your care and treatment are due at the time of service.
- All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered," or you do not have an authorization, you will be responsible for the complete charge. We will attempt to verify benefits for some specialized services or referrals; however, you remain responsible for charges to any service rendered. Patients are encouraged to contact their plans for clarification of benefits prior to services rendered.
- You must inform the office of all-insurance changes and authorization/referral requirements. In the event the office is not informed, you will be responsible for any charges denied.
- For most services provided in the hospital, we will bill your health plan. Any balance due is your responsibility.
- There are certain elective surgical procedures for which we require pre-payment. You will be informed in advance if your procedure is one of those. In that event, payment will be due one week prior to the surgery.
- Past due accounts are subject to collection proceedings. All costs incurred including, but not limited to, collection fees, attorney fees and court fees shall be your responsibility in addition to the balance due this office.
- There is a service fee of $25.00 for all returned checks. Your insurance company does not cover this fee.

Signature of Patient/Responsible Party: _____

Printed Name of Patient/Responsible Party _____ Date: _____

_____ Patient initials to indicate copy received.

Revised June 2015