NOTICE TO OUR PATIENTS

PLEASE READ THE FOLLOWING:

FINANCIAL RESPONSIBILITY: Although we participate with a variety of insurance plans, you will be held responsible for all co pays, deductibles and/or charges not covered by your insurance. In the instance that we do not participate with your insurance company, you will be held responsible for any and all charges remaining after your insurance has paid their portion.

We cannot be held responsible for monitoring your insurance. It is your responsibility to ensure the participation and/or nonparticipation of your insurance carrier. Please contact your insurance company if you have any questions regarding your obligations to your carrier, or your questions regarding your policy coverage.

If your insurance company requires a referral and you do not have one, YOU are responsible for any charges incurred.

YOU ARE RESPONSIBLE FOR THE FOLLOWING:

All co pays and deductibles.
Any services rendered without notifying us of insurance change.
Any services rendered that your insurance does not cover.
Any services rendered when your insurance is no longer active..

The approximate charge for today is $_____ for the following services:

_____

It has been explained to me, and I understand that I am responsible for charges related to the above services that were performed.

_____DATE_____ _____DATE_____

Signature of Patient Witness

If we have scheduled appointment time for you and you are unable to keep this appointment, please give us 24 h ours advance notice. Failure to do so will result in a $10.00 Missed Appointment Charge.

_____DATE_____ _____DATE_____

Signature of Patient Witness