Financial responsibility

Patient name:____________________________________MRN:___________________

Costs:
It is understood that price quotes are based upon available information at the time of the quote. Additional charges may be added to the final billing according to the level of visit, additional diagnostic testing, medication or other services ordered. The undersigned agrees that any deposits made will be applied toward charges for services rendered. Payment arrangements are available to patients; please ask for any patient business services representative.

No insurance patients:
Our goal is to treat patients without regards to their financial status. If the doctor orders tests, medication, or supplies and you're concerned about the price, please don't hesitate to ask prior to receiving the service.

Co-payment policy:
Co-payments are due at the time of service. $25 statement processing fee will be charged for any unpaid co-payments for each visit.

No-show policy:
The office may use an automated reminder system to help remind patients of their upcoming appointments. However, timely cancellation of appointments remains the responsibility of our patients. If an appointment is canceled with less than 24 hours notice, a no-show fee of $25 will be charged.

Nonsufficient funds fee:
Return check fee of $25 will be added to your account when your bank returns your check unpaid for any reason. We do not waive this bank fee.

Fee for forms:
Completion of forms not directly related to patient care is not routinely covered by clinical visit fees or by insurance. Because these take significant amount of physician time, we find it necessary to charge a fee for completion of such forms.

Fees for medical records:
A reasonable fee will be charge for providing copies of patient health information, including costs of copying, postage, and for preparation of any summary or explanation if agreed.

Fee for non-covered services:
There may be instances where your insurance does not cover certain injectable medications, immunizations, and medical supplies. Charges for those services are the responsibility of the patient. Patients are responsible for their coverage. If you have any questions, please contact your insurance.

Patient's balance:
Payment of any balance due is expected within 10 days after receipt of your statement. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay the actual attorneys fees and collection expenses. All delinquent accounts shall bear interest at the legal rate. Patient will not be allowed to see the physician unless the total current balance with the collection agency is paid in full.

The undersigned agrees, whether he/she signs as agent or the patient, to pay the account in accordance with the regular rates and terms of the office.

____________________________	____________________________	____________
Patient/Guardian Signature	Patient/Guardian Name printed	Date