NOTICE OF PATIENT FINANCIAL RESPONSIBILITY

Our office provides services in good faith that it will be appropriately compensated. It is the patients/guarantor’s responsibility to understand their individual health policy and its coverage.

 Our office will gladly file with your primary and secondary health insurance on your behalf; but requires that patient deductible, copayments & coinsurance be paid at the time of service.

Patients are responsible for letting us know of any changes in insurance coverage or other pertinent demographic information. You must provide our office with a copy of your current insurance card(s) as well as a state issued photo ID or driver’s license.

We will coordinate with your employer for work related injuries. It is the patient’s responsibility to let us know if a visit is work related.

We **do not** coordinate with third party liability (example: auto accidents, school insurance). When a third party is involved, patients are considered self pay. It is your responsibility to inform us in writing if your visit is the result of a third party liability. If claims are erroneously filed to your health insurance or retroactively reversed, then the liability becomes that of the patient/guarantor. Interest, penalties, collection costs & legal costs incurred in order to obtain patient payment becomes the responsibility of the patient/guarantor.

Patients are expected to honor their scheduled appointment times. Missed appointments, appointments not rescheduled or cancelled less than 24 business hours in advance may be subject to a **missed appointment fee of $45**. Missed appointment fees are not covered by insurance and are the full responsibility of the patient/guarantor. Multiple missed appointments may result in dismissal as a patient.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient/Guarantor Signature Date