



PATIENT PAYMENT POLICY

Thank you for choosing our practice! We participate with most insurance plans. Each plan has different benefits for you as well as different financial obligations. We will work with you and your insurance plan to determine what part of your fees for medical care are covered by insurance and which parts are your responsibility.

The following are our financial guidelines relative to financial responsibility:

- Payment is expected at the time of service. This includes co-pays, co-insurance, and deductibles.
- It is our policy not to extend professional courtesy discounts.
- For our self pay patients (patients who have no insurance coverage), we offer a 5% discount for professional services paid in full at the time of service. This does not apply to co-pays, co-insurance, deductibles, non-covered services, and medical supplies.
- For our self pay patients (patients who have no insurance coverage), we offer a 25% discount for surgical services paid in full at the time of service. This does not apply to co-pays, co-insurance, deductibles, non-covered services, and medical supplies.
- You may be charged a \$25 no-show fee for any appointments missed, not cancelled/rescheduled with a 24 hour notice.
- Any old balances on your account must be paid in full prior to receiving additional services.
- Not all insurance policies cover all services. It is your responsibility to check with your insurance company to determine covered benefits.
- Hearing Aids: MEDICARE DOES NOT PAY FOR ANY SERVICES FOR THE SOLE PURPOSE OF HEARING AID SELECTION OR EVALUATION.
- We do not accept Medicaid as a secondary payor. You will be responsible for any co-pays, co-insurance, or deductibles applicable to your primary policy.
- A parent or legal guardian must accompany patients who are minors. This accompanying adult is responsible for payment of the account.

I have read, understand, and agree to the above financial policy. I understand that charges not covered by your insurance company, as well as applicable co-pays and deductibles are my responsibility.

Printed name

Signature

Date