**FINANCIAL POLICY AND FEES**

Thank you for choosing me as your health care provider. I am committed to your successful treatment. Please understand that payment of your bill is considered part of your treatment. The following is a statement of my Financial Policy and Fees, which I require you to sign prior to any treatment.

**PAYMENT OF AN INITIAL VISIT IS EXPECTED AT THE TIME OF SERVICE.**

**BILLING STATEMENTS ARE SENT MONTHLY. P AYMENT IS EXPECTED AT THE TIME OF SERVICE. WE ACCEPT CASH OR CHECKS, NO CREDIT CARDS.**

**BOUNCED CHECKS OR OUTSTANDING BALANCES WILL BE SUBJECT TO BANK CHARGES AND COLLECTION FEES.**

**Usual and Customary Rates**

I am committed to providing the best treatment possible and I charge what is usual and customary in our area. You are responsible for payment, at my established fee schedule, regardless of any insurance company’s determination of fee schedules.

**Missed Appointments**

My policy is to charge for missed appointments at the full rate of normal office visits unless they are cancelled at least forty-eight hours in advance. Monday appointments must be cancelled the Thursday prior to an appointment. It is the patient’s responsibility to make new appointments and to cancel existing appointments they do not intend to keep.

**Prescription Refills**

Medication refills should be handled during scheduled visits. A fifteen-dollar fee will be assessed for each medication refill made outside of appointments upon request by you or your pharmacy.

**Your insurance policy is a contract between you and your insurance company. I am not a party to that contract. Any paperwork that your insurance company requires is your responsibility. Medical letters, prescription services outside of regular appointments, and forms filled out by me are all subject to a rate of up to $90.00 per fifteen minutes.**

I have read the Financial Policy and Fees outlined above and agree to this policy and fee schedule. I have also received and read a copy of the updated HIPAA Privacy Practices Notice.

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(Signature of patient or responsible party) (Date)