OUR FINANCIAL POLICY

We are committed to providing you with the best possible care, and we are pleased to discuss our financial fees with you at. any time. Your clear understanding of our Financial Policy is important to our professional relationship. Please ask if you have any questions about our fees, financial policy of your responsibility.

Free Consultations: All NEW patients receive a free initial consultation. When the patient or parent/guardian have consented to treatment or surgery, the patient is aware that there will be a charge for an office visit and they will be responsible for all charges. All patients MUST complete our patient information sheet before seeing the doctor.

Patients: Adult patients are responsible for FULL PAYMENT at the time of service. If patient has medical insurance it will be billed accordingly however, co-pays will be due at the time of service. Regarding DEDUCTIBLES, if your insurance indicates that any visits or services will be applied to a medical deductible we will require a deposit towards your deductible at the time of service.

Regarding Minors: The adult accompanying a minor, and his/her Parent(s) or Guardian(s) are responsible for FULL payment at the time of service. UNACCOMPANIED MINORS, the Parent(s) or Guardian(s) are responsible for FULL PAYMENT. Non-Emergency treatment will be denied unless charges have been pre-authorized to an APPROVED agreement.

REGARDING YOUR INSURANCE: We will not become involved in disputes between you and your insurance company regarding DEDUCTIBLES, CO-PAYMENTS, COVERED CHARGES, SECONDARY INSURANCE, "USUAL & CUSTOMARY" CHARGES, SECOND SURGICAL OPINIONS, etc., other than to supply factual information as necessary. In addition we will not become involved in disputes over which divorced parent is responsible for the costs of medical care rendered to a minor. YOU ARE RESPONSIBLE FOR YOUR OWN ACCOUNT.

MISSED APPOINTMENTS: Unless cancelled at least 24 hours in advance, our policy I to charge for missed appointments at the rate of a normal office visit. Please help us serve you better by keeping scheduled appointments

I HAVE READ AND UNDERSTAND THESE CONDITIONS.

Responsible Party Signature_____ **Date:** _____ **Relationship To Patient**_____

PRACTICE'S REQUIREMENTS REGARDING PRIVACY NOTICE:

The Practice:

- **(a) Is required by federal law to maintain the privacy of your PHI and to provide you with this Privacy Notice detailing the Practice's legal duties and privacy practices with respect to your PHI.**
- **(b) Under the Privacy Rule, it may be required by State law to grant greater access or maintain greater restrictions on the use or release of your PHI than that which is provided for under federal law.**
- **(c) Is required to abide by the terms of this Privacy Notice.**
- **(d) Reserves the right to change the terms of this Privacy Notice and to make the new Privacy Notice provisions effective for your entire PHI that it maintains.**
- **(e) Will distribute any revised Privacy Notice to you prior to implementation.**
- **(f) Will not retaliate against you for filing a complaint.**

By subscribing my name below, I acknowledge receipt of a copy of this Notice, and my understanding and my agreement to its terms.

Patient Signature_____

Date_____