Patients Name _____Date of Service _____Chart _____

It is our office policy to inform you of our patient payment procedures. Please review the section below that is applicable to you.

____1. **Patient Without Insurance (Private Pay)**
Please make payment for your care at each visit. If payment cannot be made at each visit, the front-desk staff will assist you in completing the form for financial arrangements.

____2. **Patient with Insurance**
You are responsible for deductibles, copays, noncovered services, coinsurance and items considered "not medically necessary" by your insurance company. Please pay co-payments and coinsurance amounts as services are rendered. The remaining balance should be taken care of within one (1) month of notice from insurance company. If you or your insurance carrier makes payment exceeding your balance, reimbursement will be remitted. If payment cannot be made at each visit notify the front-desk staff to make other arrangements.

____3. **Worker's Compensation Patient**
As a Worker's Compensation patient you may be covered by insurance if your injury is reported at work and verified with your employer. Be sure to inform the office personnel that your injury resulted during employment and fill out the below information. **Patient is ultimately responsible for balance**.

____4. **Personal Injury (Accident)**
If you are a personal-injury patient, our office will bill your insurance company. We will not file Third Party Insurance. If we are unable to obtain payment, the charges for the services rendered will be your responsibility. Please give all information needed for billing below. If an attorney is involved and asks you not to submit insurance claims, a doctor's lien must be signed by you and your attorney.

____5. **Medicare**
Our office will submit your Medicare charges to Medicare and your secondary insurance. You are responsible for deductibles, copays, and any noncovered services.

Worker's Compensation and Personal Injury
Please fill out this information

Patient's Name _____ Date of Injury _____

Contact Person _____ Contact Phone Number _____

Current Employer _____ Contact Phone Number _____

Employer Worker's Compensation is with _____
Address

Insurance Carrier _____

Mailing Address _____

_____

Claim # _____

I have read and agree to the Financial Policy Information stated above that apply to me.

_____ _____
Patient or responsible party signature Date

_____ _____
Person signing on behalf of patient **(Please Print Name**) Reason patient unable to sign

_____
Relationship to Patient Address Phone