OFFICE FINANCIAL POLICY

Payment for services rendered is due in full at the time of service. Our office accepts cash, personal checks (with valid driver's license), and credit cards**. There is a $20.00 returned check fee due and payable from you for each check payment returned to us by your bank.**

FOR PATIENTS WITH INSURANCE: As a service to our patients, we will bill your insurance carrier, provided proper paperwork is provided to us. We will also assist you in billing your secondary insurance carrier if applicable, and in researching unpaid claims. Every effort will be made to closely estimate your co-payments and deductibles, which are due at the time of service, ***but the ultimate responsibility for any unpaid balance rests on you.*** Please understand that insurance is a contract between you and your insurance company. If an insurance carrier has not paid within 60 days of billing, any unpaid professional fees are due and payable in full from you.

ASSIGNMENT OF INSURNCE BENEFITS: Patients with insurance coverage, please read and sign below: I hereby assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, private insurance, and any other health plans, to Dr. Greg A. Roberts. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered to be valid as the original. I understand that I am financially responsible for all charges whether or not paid by my insurance carrier. I hereby authorize said assignee to release all information necessary to secure the payment.

X SIGNATURE _____**DATE**_____

MANAGED CARE PARTICIPANTS: Some benefit plans require pre-authorization and specialist referral from your primary physician. Please provide the proper insurance plan identification and forms necessary prior to your visit. All co-payments or patient out-of-pocket fees are due and payable at the time of service.

SURGERY FEES: All co-payments, deductibles and payments for non-covered surgical procedures are due prior to your surgery. ***YOUR INSURANCE CARRIER MAY REQUIRE CONSULTATION WITH PRIOR AUTHORIZATION.***

NON-COVERED CHARGES: Any charges not paid by your insurance carrier will require payment in full at the time services are provided or upon notice of insurance claim denial. To assist our patients, we offer alternative financing sources. Please ask our billing personnel for additional information.

WORKERS COMPENSATION: If your injury is work-related, we require the necessary insurance billing information and employer authorization form prior to your office visit or treatment.

PERSONAL INJURY CASES: This office does not accept liens, nor bill for auto-accident or other liability or lawsuit-related cases. The patient is responsible for services provided at the time of service. If injury cases are accepted: The patient is required to complete the authorization to pay from settlement and agreement to pay forms and liens, and to provide insurance billing information.

CANCELLATION OF APPOINTMENTS: Our goal is to provide high quality of care at low cost to our patients and in fairness to other patients and the doctor; we require at least 24 hours' notice when canceling an appointment. There is a **$25.00 fee for missed appointments without 24 hours' notification**, which will be due and payable from you. The practice reserves the right to dismiss patients with excessive cancelled appointments.

MEDICARE PATIENTS: I request payment of authorized Medicare benefits to be made either to me or on my behalf to Dr. Greg A. Roberts for services provided me by the listed physician. I authorize any holder of medical information about me to be release to the Health Care Financing Administration and its agents, any information needed to determine these benefits or the benefits payable to related services. I understand that my signature requests payment to be made and authorize release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes the release of information to the insurer or agency shown. In Medicare-assigned cases, the provider agrees to accept the charge determination of the Medicare carrier as the full charge and the patient is responsible only for the deductible, coinsurance and ***non-covered services*** (**such as any dental procedures)** at the time of service. Coinsurance and the deductibles are based upon the charge determination of the Medicare carrier.

X SIGNATURE _____**Date**_____

FOR ALL PATIENTS: I have read and agree to the above financial policy for payment and professional fees. I understand that I am ultimately responsible for all fees for services provided to me. The undersigned specifically agrees to pay all reasonable attorney fees and court costs in the event legal action is taken to collect on this account. The undersigned further agrees to pay an additional amount representing forty percent (40%) of the principal balance if the account is referred to a collection agency or attorney for collection. This additional amount is in recognition of the costs associated with said collection action processing.

X PLEASE PRINT NAME _____

X SIGNATURE _____**DATE**_____