Payment Policy & Authorization

We are committed to meeting your healthcare needs and keeping your insurance and other financial arrangements as simple as possible. In order to accomplish this for all our clients, we ask that you adhere to our practice's financial policy. By signing below, you are agreeing to its terms.

1. All co-payment, self-pay services, and additional payment this practice determines will not be reimbursed by my insurance provider are due at the time of service.
2. I am financially responsible for payment of charges for services I receive from this practice. As a convenience, this practice will submit claims for reimbursement with my insurance provider.
3. This practice may deny service or charge a service fee for failure to pay a co-pay or any outstanding balance at the time of service.
4. It is my responsibility to provide my current address, telephone number, email address, and insurance information at each visit.
5. It is my responsibility to familiarize myself with my insurance plan and its policies. Any questions about my health insurance coverage or benefit levels should be directed to my health plan.
6. I agree to provide the above practice and/or its designated payment agent with my debit/credit card information. I understand that my signature and payment information will be maintained on file for future use by the practice.
7. The applicable payment card will be securely stored by the payment agent in order to help maintain the security of my payment information.
8. If warranted, this practice may offer the option of paying my share of costs via an automated payment plan. I understand that I may incur some interest expense beyond my balance in exchange for this convenience. I can avoid interest charges by paying my bill immediately if required or by its due date.
9. I authorize the above practice and/or its designated payment agent to apply charges to my payment card for all amounts owed to the practice for medical visits, procedures or supplies, including: (i) amounts agreed as part of a payment plan, (ii) copayments, (iii) coinsurance (after application of insurance proceeds), (iv) amounts not covered by insurance and/or (v) fees (if applicable) charged by the practice for failure to keep a scheduled appointment or provide timely notice of appointment cancellation.
10. In the case of a client balance that is not satisfied by a charge to my payment method or a payment plan, I may receive a monthly statement for any outstanding balance. I am responsible for paying this balance by its due date in order to avoid paying possible interest on the balance.
11. You will be provided with advance notice of all payments.
12. Transaction receipts will be maintained in the client file or will be emailed to me if I provide and maintain a valid email address.
13. I authorize the above practice and/or its designated provider to send electronic account statements and invoices to my email address on file. I understand that it is my responsibility to maintain a current email address on file and that I will not receive a mailed copy of any electronic statement.

This authorization will remain in effect until I provide written notice of cancellation to the practice. Authorization for services already rendered cannot be cancelled or refunded. I agree to notify the practice in writing of any changes in my payment or other information.

We may change the terms of our policy, at any time. The new policy will be effective at that time. Upon your request, we will provide you with a revised policy. You may request a revised version by calling the office and requesting that a revised copy be sent via email or asking for one at the time of your next appointment.