CREDIT POLICY

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READ CAREFULLY BEFORE SIGNING

In the interest of good health care practice, it is desirable to establish a policy to avoid misunderstanding. Our primary responsibility is to help our patients experience good health, and we wish to spend our time and energy toward that end. Therefore, we wish to clarify the following points.

1. **Co-pays and co-insurance are due at the time of service.** We re not set up for any type of credit or debit cards. We accept cash or checks. If payment can not be made in full, a monthly statement can be mailed and if a payment is made every month the account will be considered current. Payment is due on all accounts (with the exception of 100 percent coverage) upon receipt of the monthly statement. Past due accounts will be charged an interest fee of 1.5 percent, with a minimum of $1.00.

2. **There is no payment due from any patient who is treating for a current worker's compensation or auto accident.** We will bill your charges directly to the insurance company responsible.

3. Our office will bill Medicare for you twice a month. **Medicare will make payment directly to you. We do not accept assignment.** Therefore, you must make payment to this office. Medicare will not pay for any examination, only treatment.

4. Even though our office will be billing your insurance for you, you will still receive a statement each month for the outstanding balance of your account. **A monthly payment must be made on the outstanding patient balance to keep your account current. We cannot accept responsibility for collecting an insurance claim or negotiating a disputed claim. Insurance reimbursement is a contract between you and your carrier. You are responsible for payment on your account within the usual limits of our credit policy.** If an overpayment on your account leaves a credit balance, a check will be mailed to you following your notification to us of a credit.

5. It is not our intention to cause you undue hardship, however, we must collect our receivables as efficiently as possible in order to continue our service to the community.

6. We ask all of our patients to sign this policy. We have no reason to believe that your insurance company, whether it is private, auto or worker's compensation will not be paying for your care, but if that should happen, please understand that you are ultimately responsible for all charges incurred.

I have read this credit policy and understand that regardless of any insurance coverage I may have, I am responsible for payment of my account within the usual limit of this credit policy. I agree that in the event costs and/or fees are incurred in connection with the collection of my account, I will pay for all such costs and fees, including collection costs, attorney's fees, and all court costs. I authorize the release of any medical or other information necessary to process my claims. I authorize payment of medical benefits to this physician for services performed and billed.

Date	Signature of responsible party
Patient's name if a minor	Print responsible party's name