

## OFFICE POLICY

Welcome to our office. We are committed to providing you with the best possible care. In order to achieve that goal, your understanding of our office policy is essential. Please read this carefully and sign the bottom of the page.

### Your signature indicates that you have read the following:

1. **Co-payment** It must be paid before you see the doctor or have your prescribed treatment. If you arrive for your visit without your co-pay, you may be asked to reschedule.
2. **Deductibles** If you have a deductible, you will be required to pay a percentage of the cost of your visit before you leave our office.
3. **Referrals** If your insurance requires that you have a current referral to see us, you must obtain one prior to your visit. Otherwise, you will be responsible for the full cost of your visit.
4. **Patient Balances** These must be paid prior to your next appointment, unless otherwise arranged in advance by our billing staff.
5. **Returned Checks** You will be responsible for the original amount of your check plus an additional charge of \$35.
6. **Missed Appointments** If you are unable to keep your appointment, we require 24 hours notice. There is a \$50 charge for missed appointments.
7. **Coverage** Your insurance is a contract between you and your insurance company. We are not a party to that contract. You must familiarize yourself with the details of your coverage as we cannot research your policy at your visit.
8. **Non-covered Services** Not all services, such as cosmetic procedures, are covered benefits in all contracts. In such cases, you will be asked to pay in full at the time of your visit. We can provide you with claim information by request.
9. **Lateness** If you arrive more than 20 minutes late, the doctor will see you at his/her discretion. You may be asked to reschedule.

**I have read this information sheet and agree to abide by the policies of this practice.**

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**Signature**

**Date**