



**FINANCIAL POLICY
AGREEMENT**

Thank you for choosing us as your health care provider. We are committed to your successful treatment. The following statement explains our Financial Policy, which we require you to read and sign prior to receiving any services.

It is the policy of this office that **all outstanding balances are to be paid in full** upon receipt of a current statement. All patients must complete our registration form annually.

We accept cash, checks and Visa, MasterCard, or Discover. Fees are assessed for any returned checks in addition to bank fees.

Insurance:

As a courtesy, we will submit your claim for all services to your insurance company. Please remember your individual health insurance policy is a contract between you and your insurance company, and we are not a party to that contract. Be aware that some of our services may not be covered by your insurance policy.

By presenting for care, you agree that you are responsible for all services and charges, regardless of your insurance status. Should any provided services not be covered by your insurance, we will not alter your claim, change your diagnosis, or report a different service than what was performed in order that your insurance will cover the charge. You will be responsible for the balance.

Minor Patients:

The adults accompanying a minor and the parents (or guardians of the minor) are responsible for payment of co-pays.

Acknowledgement and Acceptance:

I have read and fully understand the above. I authorize the release of information for the purpose of payment and insurance benefits and authorize payment directly to Melius, Schurr & Cardwell for services rendered to me and/or my dependents.

I further accept responsibility for the payment of co-payments, deductibles and coinsurance, as well as any services **that are not covered or paid by my plan.**

Balances due on my account shall be paid in full upon receipt of a current statement.

(Patient/Authorized Representative Signature)

(Date)

MEDICARE PATIENTS ONLY

I authorize the release of any medical information necessary to process claims. I request payment of my Medicare benefits to Melius, Schurr, and Cardwell, LLP for services rendered.

(Patient/Authorized Representative Signature)

(Date)