



**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 before their first appointment.

We accept cash, checks and Visa or MasterCard. A \$35.00 fee is assessed for any returned checks in addition to bank fees.

Insurance:

We accept a variety of insurances and are participating providers for several others. Your insurance policy is a contract between you and your insurance company. As a courtesy to our patients, we submit claims to your insurance company, but it is your responsibility to verify what services are covered. **All co-pays are due at the time of service**; if you have a coinsurance, we will bill you directly.

Our practice is committed to providing the best treatment available to our patients, and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

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)