FINANCIAL POLICY

FOR YOUR CONVENIENCE WE WILL SUBMIT TO YOUR INSURANCE CLAIM FOR REIMBURSEMENT. WAIVING DEDUCTIBLES AND COPAYMENTS IS ILLEGAL. ALL PATIENTS ARE RESPONSIBLE FOR THEIR DEDUCTIBLE AND THE REMAINING PERCENTAGE AND/OR CHARGES NOT COVERED BY INSURANCE. PAYMENT IS EXPECTED AT TIME THE SERVICE IS RENDERED BY CASH, CHECK, CREDIT OR DEBIT CARD.

IF YOU HAVE ANY QUESTIONS REGARDING YOUR BILLING PLEASE FEEL FREE TO DISCUSS THEM WITH OUR OFFICE PERSONNEL.

INSURANCE INFORMATION

_____

PLEASE CHECK APPROPRIATE BOX:

[ ] MOTOR VEHICLE [ ] MEDICARE [ ] WORKMAN'S COMP [ ] SELF PAY [ ] HEALTH INSURANCE

[X] DATE OF ACCIDENT/INJURY : (MONTH, DATE, YEAR) _____/_____/_____

PRIMARY INSURANCE:

NAME OF INSURANCE COMPANY:
_____

SUBSCRIBER'S NAME:
_____

SUBSCRIBER'S BIRTHDATE : ____/____/____ RELATIONSHIP TO PATIENT:
_____

INSURANCE ID# _____ GROUP # :
_____
CLAIM OR POLICY # : _____
IF AUTO ACCIDENT OR WORKERS COMP

**** IF THIS IS AN INJURY/ACCIDENT AND YOU ARE PURSUING A LAW SUIT, PLEASE PROVIDE ATTORNEY NAME, PHONE AND ADDRESS:**

_____
_____

DO YOU HAVE A SECONDARY INSURANCE? Y/N: _____ INSURANCE COMPANY: _____

SUBSCRIBER : _____ BIRTHDATE: _____/_____/_____

PATIENTS RIGHTS AND RESPONSIBILITIES

A PATIENT HAS THE RIGHT TO BE INFORMED OF SPECIFIC DETAILS ABOUT PROCEDURES, TREATMENTS AND COSTS IN ORDER TO MAKE INFORMED DECISIONS.

PRIVACY AND CONFIDENTIALITY: PHYSICAL PRIVACY AND APPROPRIATE PHYSICAL DISTANCING WILL BE ENSURED DURING ANY TREATMENT.

QUESTIONS AND COMPLAINTS: A PATIENT'S QUESTION OR GRIEVANCE SHOULD BE GIVEN TO OFFICE MANAGER

CANCELLATIONS: I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO GIVE AT LEAST 24 HOURS NOTICE. IN THE CASE OF INCLEMENT WEATHER DURING WINTER MONTHS, PLEASE CONTACT OUR OFFICE TO CONFIRM WE ARE OPEN.

SIGNATURE OF PATIENT: _____ DATE: ____/____/____

(PARENT OR GUARDIAN IF PATIENT IS A MINOR)