Continuum of Financial Responsibility Policy

Due to rising costs in health care, we have implemented the following fees. Please take the time to review, sign, and date.

FORMS – following fee apply if patient is requesting forms without an appointment.

$30 Leave of Absence/Family Leave (FMLA)

$30 Short Term Disability

$15 Other Third Party Correspondence

$10 Medical Certificate (e.g. Jury Duty, Gym Membership, Flexible Savings Accounts)

Medical Records

$25 Medical Records

$50-100 Third party requesting records

Missed appointments or late cancelations (We require a 24 hour cancelation)

$25 Follow-up

$50 Physical Exam

$30 Bounced check fee

Your signature indicates that you have read and understand our financial policy and agree to abide by it.

_____ _____

SIGNATURE **DATE**

Disclaimer for Non-Covered Services or Out-of-Network Services

It is in your interest to know whether your physician is contracted with your insurance company. In addition, it is you responsibility to understand your benefits, deductibles, co-insurance, and co-pays prior to your visits.

The purpose of this document is to help you make an informed choice about whether or not you want to receive medical services, knowing that you might be personally financially responsible. Before you make a decision about your options, you should read this entire document carefully. If you still have questions, please don't hesitate to ask the staff or providers.

Your insurance company may deny the claim for reasons listed below:

- Out of network provider
- Non Covered Services
- A result of medical service(s) not being deemed a medical necessity by the insurance company.
- Deductible
- Policy has been terminated for the date the service was performed.

The fact that your insurance may not pay for a particular service(s) does not mean that you should not receive the service(s). There may be a good reason your doctor recommended this treatment.

By signing below you are acknowledging that you've read and understood reasons your insurance may deny a claim.

_____ _____

Signature of patient or person acting on patient's behalf Date