



**Office Policy & Financial Agreement**

**Insurance:**

We will submit a claim to your insurance company, provided you supply all the required information. If your insurance company fails to pay within a reasonable amount of time, you will be expected to pay for the service. \_\_\_\_ **(Initials)**

Your financial responsibility depends on the coverage provided by your policy, *which you as the patient need to know and understand your policy and benefits.* You are responsible for paying any co-payment and/or deductibles/co-insurance or non-covered services at the time the service is provided. Your plan may require a referral for a specialist office visit. It is the patient’s responsibility to obtain referral and make sure our office receives it before any service will be provided. \_\_\_\_ **(Initials)**

**Workers Compensation:**

You may become liable for your balance if your claim is found to be non-compensable. \_\_\_\_ **(Initials)**

Is there a possibility this injury could be work related? \_\_\_\_ **YES** \_\_\_\_ **NO** \_\_\_\_ **(Initials)**

**Minor Patients:**

For all services rendered to minor patients, we will look to the adult accompanying the patient and the parent/ guardian with custody for payment and signature of this policy. If parent/ guardian are unable to attend we have a signed consent form for you to fill out.

**Delinquent accounts:**

We refer delinquent account to outside collections agencies for recovery when full payment has not been received after a prescribed number of statements and verbal contacts with you or the responsible party. Should it become necessary for us to refer your account to a collection agency, you will be responsible for all fees incurred and charged to us by the collections agency for recovery on your delinquent account balance. \*In the event you issue a check that is issued but not honored and paid by your financial institution, you will be charged a \$30.00 returned check fee and a \$4.00 bank fee. \_\_\_\_ **(Initials)**

**Durable Medical Equipment:** If you receive any DME’s that your insurance does not cover, you will be responsible as the patient for payment. You will not be able to return the item. (DME’s include, but are not limited to: braces, slings, walking boots, & tens units/e-stem machines)

**By signing below, I acknowledge, understand, and agree to the above information.**

---

Patient Signature                                  Date                                  Responsible Party Signature                  Relationship