FINANCIAL POLICY

It is our mission to provide you with quality care. Please understand that payment of your bill is considered part of your obligation as a patient. The following information is provided to avoid any misunderstanding or disagreement concerning payment of services provided by our office. Our front desk and billing staff will be happy to assist in answering any further questions you may have.

Our office participates with a variety of insurance plans. It is your responsibility to bring your current insurance card to every visit and notify us of changes in coverage.

Payment of co-pays is required on the day of your visit. Payment can be made by cash, check or credit card.

You must obtain any referrals your insurance company requires prior to your appointment. Your appointment may be rescheduled if a referral is required and is not in place at the time of service. If a referral was required for your visit and not obtained by you, you will be responsible for any charges.

We will submit a claim to your insurance company for you. Balances not paid by your primary insurance company may be billed to your secondary payer. Ultimately, you are responsible for payment of charges.

A monthly statement will be sent to you. All balances are due within 30 days of the statement date. Unpaid balances greater than 60 days are subject to our collection process.

There is a fee of $25.00 on all returned checks.

A fee of $25.00 will be charged for all appointments that are not kept or cancelled within 24 hours prior to the appointment time. Upon request, your physician may agree to waive this fee for unforeseen circumstances.

Your physician may order a procedure or test to be performed either in our office or outside the office. You will need to contact your insurance company to check your benefits for outpatient procedures or tests.

If you have questions about your insurance, we will be happy to assist you. Specific coverage issues however, should be directed to your insurance company's member services department (the contact number should be on your insurance card).

By signing the detached paper, I certify that I will pay Dayton Arthritis & Allergy Center any co-payments, co-insurances, deductibles or non-covered services. I will also be responsible for any amounts not paid by insurance due to not providing the appropriate insurance information for billing purposes.

SIGN _____