COMPLETING INFORMATION SHEET

1. a) Without the INFORMATION COMPLETE you will be considered a personal pay account.
   b) We need copies of your insurance card or cards for our files.
   c) Proper group NUMBERS and Social Security NUMBERS of both insurances are required with the name of the person who carries the insurance. We are aware that *not* everyone has 2 insurance coverages.
   d) RESPONSIBLE PARTY IS THE PERSON SIGNING THIS FORM. *THANK YOU FOR YOUR COOPERATION. BY GIVING US ALL THE ACCURATE INFORMATION, WE CAN SERVE YOU BETTER AND MORE EFFICIENTLY.*
2. **WE EXPECT YOU TO KNOW AND UNDERSTAND YOUR INSURANCE POLICY.**
3. Insurance is usually not designed to pay the entire fee. Because insurance companies vary in the amount they will pay for various services, it is ultimately your responsibility to pay that portion of the bill not paid by your insurance company (unless otherwise restricted by law or agreement we might have with your insurer). FOR UN-INSURED PATIENTS, WE REQUEST PAYMENT ARRANGEMENTS BE MADE *BEFORE* YOUR VISIT.
4. AS A COURTESY we will file your INSURANCE, (if you do file your own insurance, you need to pay for your services today.) We do *not* accept what the auto insurance pays as payment in full.
5. If your INSURANCE requires a SPECIAL CLAIM FORM, we must have it WITHIN 2 WORKING days or the INSURANCE BILLING will be processed and sent without it.
6. If your visit is related to AN INJURY at work, YOU MUST REPORT it to the RECEPTIONIST. A special form needs to be completed. The PATIENT does not file on his work related injury (INDUSTRIAL) IT MUST BE DONE BY THIS OFFICE. Patients will continue to receive statements for their record-until we are satisfied by the INSURANCE.
7. PATIENTS WITHOUT INSURANCE WILL BE CASH VISITS. (Special arrangements can be made for large accounts).
8. In accordance with the FEDERAL TRUTH-IN-LENDING ACT, all doctors are required to give to their patient's complete information in connection with the extension of credit.
   a) BASIC POLICY: The patient is responsible for all medical bills in our office. Our staff will help with completion of insurance forms as an accommodation and convenience to you, without charge. It is the patient's responsibility to know your contract benefits, assure collection of insurance payments to us and to negotiate with your insurance company over any dispute claims.
9. **WORKMAN'S COMPENSATION**: In the event it is determined by the Worker's Compensation board that the illness or injury is not a result of a compensated Worker's Compensation case, I hereby agree to pay usual and customary fees for services rendered.
10. **REJECTED CLAIMS**: If your insurance company rejects your claim, policy requires you to pay the balance in full upon receipt of your statement. If you cannot pay in full, contact our Business Office.
11. **FEES**: a) A **$25.00** *handling charge* is applied to all returned checks.
    b) Our office will charge a **$25.00** no *show fee* for patients that miss their appointment without prior notice.
    c) A **$25.00** cancellation fee applies when patients cancel within a 24 hour period without reasonable cause.
12. **DELINQUENT ACCOUNTS**: If the insured or undersigned fails to timely pay on the amount owed, the health care provider may make a report to a credit bureau or use the service of a collection agency and such actions may negatively impact the insured's credit score. Delinquent accounts over 90 days are turned over to our Collection Manager. If the bill remains unpaid and satisfactory arrangements for payment are not made, the Collection Manager will review the account with the Clinic Owner to decide appropriate legal action. We reserve the right to add late charges up to 40% for delinquent accounts requiring collection action and to add attorneys' fees and court costs. If the account must be referred to an outside collection agency, and you have opted out of receiving a final notice for the delinquent account by text or email on number 16 below, a letter via certified mail or priority mail will be sent. In sending this letter, a fee of $6.00 will be added on top of the 25% collection fee when the balance is reported. If this action is taken, the Collection Manager will require that 50 to 100% of the balance be paid before the patient can be seen again.
    a) If this account is assigned to an attorney for collection and/or suit, the prevailing party shall be entitled to reasonable attorneys' fees and costs of collection.
13. **MONTHLY STATEMENTS**: You will receive an itemized monthly statement until your bill is paid in full whether or not you have insurance. This is a courtesy to you to be aware of the status of payments on your account and have a record of services. Once your insurance has paid, you are responsible for the unpaid balance.
14. **UNINSURED PATIENTS**: Our office will give all patients without insurance a 20% discount if they pay at the time of the office visit. If the patient is not able to provide this amount they must pay a co-pay before being seen and our Billing Company will bill the patient for the remaining amount.
15. **COPAYS** are due at time of service. If not paid before closing time on appointment date, a $15.00 processing fee will be charged in addition to copay.
16. **Text Messaging:** We want to stay in touch with you regarding your account and its collection status regarding past due balances. In order for us to contact you regarding all past due accounts and any collection status they may have, you expressly authorize us to contact you by the telephone by sending text messages or e-mails at any number or email you have listed. You acknowledge that such contact could result in charges to you by your telephone carrier. Methods of contact may include the use of pre-recorded/artificial voice messages and/or the use of an automatic telephone dialing system, as applicable. You acknowledge and agree that this authorization shall extend to any billing or collection company or companies which may be assigned

Yes, I authorize this (initials):_____ No, I do not authorize this (initials): _____

I have read and agree to the Financial Policy of this office.

Patient (print): _____Date of Birth:_____ Date: _____

Patient or Patient Representative Signature: _____