## PATIENT FINANCIAL RESPONSIBILITY

In order to reduce confusion and misunderstanding between our patients and the practice, we have adopted the following financial policy. If you have any questions about the policy, please discuss them with the office manager. We are dedicated to providing the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

Your insurance policy is a contract between you and your insurance company, the doctor is not involved. As a courtesy, we will file your insurance claim for you if you assign the benefits to the doctor, in other words, you agree to have your insurance company pay the doctor directly. If your insurance company does not pay the practice within a reasonable length of time, we will look to you for payment. Please be advised that some insurances require you to meet a deductible. If at the time of your visit this has not been met, you will be required to pay for services rendered that day.

We do have prior arrangements with many insurers and other health plans and do accept assignment of benefits. We will bill those plans for which we have an agreement and will require you to pay the authorized co-payment at the time of service. We will collect your co-payment upon arrival of your appointment.

If you have insurance coverage with a plan that we do not have a prior agreement with, we will prepare and send the claim for you on an assignment basis. This means your insurer will send the payment directly to you. Therefore, our charges for your care and treatment are due at the time of service.

All health plans are not the same and do not cover the same services. In the event your health plan determines a service to be "not covered", you will be responsible for the charges. Payment is due upon receipt of a statement from our office.

In order to provide the best possible service and availability to all our patients, please call us at least 24 hours prior to your appointment to cancel or reschedule to avoid a $25.00 fee.

I have read and understand this policy.

Patient Signature ______________________________ Date ______________

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3100 CORAL HILLS DRIVE #206, CORAL SPRINGS, FL 33065, PHONE: 954-575-4711 FAX: 954-575-4722