



Provider#: _____

Account#: _____

Financial Policy

Thank you for choosing our practice! We believe that establishing a written financial policy is mutually beneficial for all parties. It is our goal to avoid any miscommunication or concerns regarding financial matters in order to focus our energies on providing healthcare services to our patients. Our staff is available to assist you should you have any questions. Our financial policy is as follows:

1. **Payment - Payment is expected at the time of service.** This includes co-pays, co-insurance, and deductibles.
2. **Insurance -**
 - a. **Insurance Card** – Please provide a copy of your insurance card prior to each visit.
 - b. **Insurance Claims** – We will file insurance for you under most circumstances as long as you provide us with current information on your insurance plan. Each plan has different benefits for you as well as different financial obligations. Not all insurance policies cover all services. You are ultimately responsible for understanding the details of any particular coverage you may have as well as the payment of all charges you incur.
 - c. **Unpaid Insurance Claims** – If your insurance company has not responded to us within 60 days of a filed insurance claim, the charges will be sent to you directly and you will be responsible for their payment as well as for payment of any other charges incurred consistent with this financial policy.
 - d. **Liability Insurance** – We do not accept liability insurance in our office.
3. **Minor Children Patients –**
 - a. **Responsible Party** - It is required that a parent or legal guardian accompany patients who are minors.
 - b. **Charges** – Charges for services rendered to minor children are the responsibility of the parent who seeks treatment for the child and are due at the time of service.
 - c. **Minor Children of Divorced Parents** – Payments, copays, coinsurance and deductibles are due at the time of service from the parent who seeks treatment for the child regardless of any court-ordered responsibility for medical costs.
 - d. **Financial Responsibility of Both Parents** – The stated terms of this Financial Policy shall not modify the duty of both parents to provide for the welfare of their minor children. We expressly reserve the right to hold either or both parents responsible for any and all reasonable and necessary medical expenses.
4. **Surgery Deposits** – Remaining deductible and estimated co-insurance amounts will be expected prior to surgery. Please contact one of our Financial Counselors to make arrangements.
5. **Self-Pay Patient Discounts** – We offer a 30% discount to our self-pay patients when payment is satisfied at the time of service. Self-Pay Patient Discounts do not apply to co-pays, co-insurance, deductibles, non-covered services in some instances, and medical supplies.
6. **No Professional Courtesy Discounts** - It is our policy not to extend professional courtesy discounts.
7. **Restricted Service** – Old balances on your account are to be paid in full prior to receiving additional routine services. Please contact one of our Financial Counselors if you are unable to pay an old balance or if you have questions.
8. **Missed Appointment Charge** – If you fail to keep a scheduled appointment/procedure and do not give our office at least 24 hours advance notice of cancellation, you may be charged a **\$25 - \$50 no-show fee** depending on the type of appointment.
9. **Additional Service Charges** – A **service charge of \$35** will be added for returned checks. Unresolved return checks will be sent to the Worthless Check Division of the local court house. Should your check be reported, you will be responsible for all associated court cost.
10. **Interest** in the amount of 1.5% monthly (18% annually) may be applied to accounts with an outstanding balance after 60 days (governed by state law).
11. **Collection Costs, Court Costs, and Attorney Fees –**
 - a. Accounts may be **turned over to a third party for collection if past due 60 days** or more.
 - b. Should your account become delinquent and be referred to a third party for collection, you will be responsible for all collection costs, court costs, and reasonable attorneys’ fees as defined by N.C. GEN. STAT. § 6-21.2.

I have read, understand, and agree to the above Financial Policy. I understand that charges not covered by my insurance company, as well as applicable co-pays and deductibles are my responsibility.

Patient Printed Name

Patient Signature or Authorized Person

Date

Witness

Relationship to Patient