PAYMENT POLICY

We are committed to providing you with quality and affordable health care. Please read the following policy regarding patient and insurance responsibility for services rendered. If you have any questions after reading the information below, please contact our business office at (931) 722-2778. They are open Monday thru Friday, 8am to 5pm.

Please read and initial each statement.

_________ Self-Pay: If you are without insurance coverage, or are not insured by a plan we are contracted with, please contact our business office to make arrangements for a self-pay rate.

_________Insurance: If you are insured by a plan we are contracted with, we will, as courtesy, submit a claim for your visits. If you do not have an up to date insurance card, or if your eligibility has changed or been terminated, you are responsible for the full cost of the visits. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

_________Co-Pays and Deductibles: If you are insured by a plan we are contracted with, we will, as courtesy, submit a claim for your visits. If you do not have an up to date insurance card, or if your eligibility has changed or been terminated, you are responsible for the full cost of the visits. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage. This is a charge from your insurance company that is set when you sign your agreement with them.

_________Non-Covered Services: Please be aware that some, or perhaps all, services you receive may be non-covered services and not considered reasonable or necessary by Medicare or other insurances. You are responsible and must pay for these services.

_________Proof of Insurance: All patients must complete our patient information form before being seen for your treatment. We must obtain a copy of your driver's license and a current, valid insurance card. IT IS YOUR RESPONSIBILITY TO PROVIDE PROOF OF INSURANCE. If you fail to provide us with correct insurance information, you may be responsible for the full balance of a claim.

_________Coverage Changes: IT IS YOUR RESPONSIBILITY TO NOTIFY US OF ANY CHANGES TO YOUR INSURANCE. If your insurance changes, please notify us before your next visit so we can take the appropriate steps in order to help receive your maximum benefits.

_________Missed Appointments and Non-Compliance: We understand that you will not always be able to make your appointments. We ask that you call to cancel and/or reschedule as soon as possible. However, please note that we have an obligation to notify your doctor of any missed appointments or non-compliance with treatment.

Please be aware that your insurance coverage is a contract between you and your insurance company; we are not a party to that contract. Our practice is committed to providing the best treatment to our patients. Thank you for understanding our payment policy.

I HAVE READ AND UNDERSTAND THE PAYMENT POLICY AND AGREE TO ABIDE BY ITS GUIDELINES:

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Signature of Patient or Responsible Party Date