**HealthOne Clinic Services**

**Financial Policy:**

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 please discuss them with our billing staff. We are dedicated to providing the best possible care and service to you and regard your complete understanding of our financial policies as an essential element of your care and treatment.

Unless other arrangements have been made in advance by yourself or your health coverage carrier, full payment for office services are due at the time of service. For your convenience we will accept VISA, MasterCard, Discover, and American Express, as well as cash, check or money order.

**About Health Insurance:**

Your insurance policy is a contract between you and your insurance company. As a courtesy, we will file your insurance claim for you. If your insurance company does not pay the practice within a reasonable period, we will have to look to you for payment. If we later receive a check from your insurer we will refund any overpayment to you.

**About Participating Health Plans:**

We have made arrangements with many insurers and other health plans to accept an assignment of benefits. We will bill those plans with which we have an agreement and will only require you to pay your co-payment <u>at the time of service.</u>

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 complete charge. Payment is due upon receipt of statement from our office.

It is your responsibility to verify that this office participates with your insurance. If we do not participate with your insurance, you will likely be responsible for all charges out of pocket.

**By signing below, I acknowledge that I have read and understand the financial policy of the practice and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time-to-time by the practice.**

_____ _____

Signature Date

_____ _____

Printed Name if signed on behalf of patient Relationship to Patient