FEE POLICY

I understand that the following is a list of possible fees and information that may apply to my account with this office.

- **Co-pays:** Co-pays are due at the time of service. Your insurance coverage is an arrangement between you and your insurance company. We are happy to bill and process your claim as a courtesy to you, provided we are given the correct information.
- **Deductibles, Co-insurance & Other Charges:** You are responsible for all deductibles and charges not covered by your insurance. Please understand that we cannot, as a third party, become involved in prolonged insurance negotiations. This is your responsibility. Therefore, a portion of the estimated charges will be owed at each visit.

Outstanding Balances: Once your insurance has processed your claim, you will have 90 days to resolve your personal account balance to prevent it from going to an outside collection agency. Interest, at the annual rate of 18% (compounded monthly) will be added to any balance of 30 days, starting from the date the charge was made. You will be contacted via mail, email (if provided), and/or phone regarding your balance. Once our office has exhausted efforts in collecting outstanding balances, your credit card will be used to make past payment to our office and will be subject to our credit card on file policy. A letter informing you of the charge will be mailed or emailed and a receipt will be mailed or emailed to you. This procedure does not compromise your ability to dispute a charge or question your insurance carrier's determination of payment. In the event we are unable to collect charges owed for your services collection fees are in the amount of 33%, and your account may be subject to attorney fees, court costs, process service fees, filing fees, and any charges assessed by the collection agency to pursue this matter.

- **Supplies:** In the event that you choose to purchase supplies from our office, payment is due in full at the time of purchase pick-up. Our office will not submit charges to insurance carriers, etc. for purchase payment/reimbursement. However, if you choose, you may submit the charge and seek reimbursement personally.
- **Insurance Carrier Policy:** It is your responsibility to know your insurance benefits and coverage. Our office will assist you in verifying your insurance coverage as a courtesy. By signing this agreement, you are authorizing us to bill your insurance carrier for services. You are liable for all copayments, co-insurances, deductibles, and non-covered services as designated by your insurance carrier. If applicable, you are responsible for endorsing all insurance checks made out to you for treatment services performed at this office immediately.
- **Self-Pay/Non-Insurance Pricing:**
    - Payment is due at the time of service for all self-pay patients. The deposit required is:
        - Initial Evaluation - $125.00
        - Subsequent Treatments - $70-150.00
- **Returned Check Fee:** Returned checks will be charged an additional fee of $15.00.

I have read and understand the above terms and policies. I agree to abide as outlined above until further notice or until written notification is received which requests nullification.

_____ _____ _____

Signature of Patient or Responsible Party Date Relationship