FINANCIAL AGREEMENT

We consider all patients as “private” unless their insurance is one whom with we have a contractual agreement. We will bill your insurance as a courtesy but the balance for “private” patients is due and payable within 30 days. Many insurance plans cover a certain percentage only of the fees charged. The insurance normally only covers the “usual and customary” fees. Your insurance, as a result, may cover less than you thought they might or you may have a deductible to meet first. You may have scheduled a visit that is not covered by your insurance, such as Preventative Care, it is the patient’s responsibility to check their benefits prior to being seen.

*Please be familiar with the benefits provided by your health plan.

If your insurance requires a referral, or if we need insurance authorization prior to your visit, it is YOUR responsibility to see that your health plan requirements are met. If your insurance information or other documents needed are not provided at or prior to your first visit, any charges incurred will be your responsibility.

Co-pays are due at the time of service, if you are unable to pay your co-pay at the time of service there will be an additional $15.00 fee charged to your account. Only one non-payment of co-pays will be allowed.

No show, late cancellation fees, and co-pays must be paid prior to scheduling your next office visit.

Should the account be referred over to our collection agency, the undersigned or their agent will be responsible for payments of interest on the unpaid balance of 1% per month from the date of service, as well as collection fees, reasonable attorney fees and court costs.

We charge $35.00 for any NSF checks. (Per RCW 62A-3-515 & 520)

I acknowledge that I have read the above statement and agree to pay any charges within 30 days of receipt of statement unless other arrangements (such as contractual insurance) have been made. I authorize the physician to release information required to process my insurance claims and authorize my insurance company to make payment directly to my physician.

I HAVE READ THE FINANCIAL AGREEMENT. I UNDERSTAND AND AGREE TO THIS POLICY.

Printed Name ______________________________________ Date of Birth ______________________

Signature ____ Today’s Date ______________________