PATIENTS FINANCIAL POLICY

Your insurance company does not pay 100%. You will be responsible for the amount the insurance company does not pay.

This includes any and all co-pays, deductible and co-insurance. I understand that I am responsible for the amounts not paid and or covered by my insurance.

As an added financial responsibility, I understand I must give a 24 hour notice of an appointment cancelation or be charged a $50.00 cancelation or no show fee.

I have read and understand these policies.

Patients Name:____________________ Date of Birth:_____

Signature:_________________________ Date:_____________