

FINANCIAL POLICY

- Health Insurance companies will only pay for services that they determine to be “medically necessary” and “covered services”. Covered services are defined in the managed care plan’s certificate of coverage or group medical agreement. Every enrolled member is given a copy of these documents that are considered a contract between you and your insurance company.
- Medical necessity is determined by the representative of your insurance company upon receipt of your claim. This decision is based on the representative’s interpretation of medically necessary procedures. If your insurance plan determines that a service is not medically necessary or is not covered, as defined by your particular plan, then the insurance company will **not** pay for the service.
- In certain cases, your provider, based on their medical opinion, may request that a service/test be performed that may or may not be considered “covered” or “medically necessary” as defined in your certificate of coverage. Examples of these services include but are not limited to: Routine Exams, Office Visits, Certain screening or diagnostic tests, Skin lesion removal or biopsy, Cutting or trimming of nails and/or calluses, Durable Medical Equipment, or Other special procedures.
- If you have a question or concern about a procedure that may not be covered by your insurance company, we encourage you to **contact your insurance company directly**.
- If the office does not participate with or accept assignment from your health insurance, payment in full will be due at the time of service unless prior arrangements have been made.
- Office visit co-payments are due at the time of service. If you do not have your copay in the form of cash, Visa or MasterCard, you will be asked to reschedule your appointment.
- If you are a “Self-Pay” or uninsured patient, payment for all services must be made at the time of service. **No exceptions will be made**. Please ask for a CareCredit® application if you do not have funds available for your services.
- We are happy to file a claim on your behalf to your Health Insurance Company; however, once the insurance company is billed, we allow 60 days for the balance to be paid by your insurance company. If they do not remit payment within 60 days, the balance will be due in full from you.
- Claim denials due to no referral or authorization are the responsibility of the patient. Our office staff will assist you in referral/pre-certification procedures, but final responsibility lies with the patient.
- We encourage our patients to be familiar with their insurance plan. If your plan states your services are not covered, you will be responsible for payment.
- You will be responsible for payment in full if your insurance states that your coverage is no longer active or another insurance is primary.
- All unpaid balances are subject to a 2% interest or minimum \$5.00 service charge after 90 days.
- Please be on time for your appointment. If you need to reschedule your appointment, we require a minimum of 24 hours notice. If you miss a scheduled appointment without notifying our office, a \$25.00 charge will be added to your account.
- Due to State and Federal Law, we **must** pursue all unpaid balances to the fullest extent. Any balance that is not paid after 90 days will be sent to collections.
- If your account must be forwarded to a collection service and/or attorney for non-payment, you will be responsible for all collection fees charged by these services.
- By accepting service from our office you are acknowledging and agreeing to the terms of our office’s financial policy.

*A copy of this [Financial Policy](#) is available upon your request.