We are committed to providing you with the best possible care.

In order to achieve this goal, we need your assistance and understanding of our payment policy. The following is a statement of our financial policy, which we request you read and sign prior to treatment.

If we are participating providers with your insurance company, we will bill them for any eligible charges you may incur. You will be responsible for your co-pay, non-covered services and deductible amounts in accordance with your policy provisions.

If you belong to an HMO, you must have the required referral form from your PCP at the time of your visit. If a referral form is not available at the time of your visit, you will need to reschedule your appointment.

If we are not participating providers with your insurance carrier, full payment is required at the time of your visit. Most insurance companies have their own fee schedule and it rarely is the same as the physicians. Your health insurance coverage is a contract between you and your insurance carrier. Please direct any questions regarding payment to them.

Medicare: All of our doctors participate with Medicare. Your claim will be filed for you. At the time of service, you will be requested to pay your portion of Medicare's fee schedule. If you have a secondary insurance that we participate with, you will not be required to pay at the time of service. If any balance remains after payment by the secondary insurance, we request timely payment of the balance.

Please be advised that this practice reserves the right to assess charges for missed appointments if 24 hours is not given or if the patient arrives too late for our physicican to see you at your scheduled time. Please understand this is a courtesy to your fellow patients and will allow us the opportunity to see patients in a more timely manner.

I HAVE READ AND UNDERSTAND THE FINANCIAL POLICY AND AGREE TO BE FINANCIALLY RESPONSIBLE FOR MY TREATMENT.

SIGNATURE_____ DATE_____

ACKNOWLEDGEMENT & CONSENT OF NOTIFICATION OF PRIVACY PRACTICES-MOPM

By signing below, I acknowledge that I have been advised of how health information about me may be used as disclosed by this practice. By signing below, I consent to the use and disclosure of my health information to treat me and arrange for my medical care, to seek and receive payment for services given to me, and for the business operations of this practice and its staff.

SIGNATURE_____ DATE_____