

FINANCIAL POLICY

WE ARE COMMITTED TO PROVIDING YOU WITH THE BEST CARE, AND WE ARE PLEASED TO DISCUSS OUR PROFESSIONAL FEES WITH YOU AT ANY TIME. YOUR CLEAR UNDERSTANDING OF OUR FINANCIAL POLICY IS IMPORTANT TO OUR PROFESSIONAL RELATIONSHIP. PLEASE ASK IF YOU HAVE ANY QUESTIONS ABOUT OUR FEES, FINANCIAL POLICY, AND WHAT YOUR RESPONSIBILITY WILL BE.

- ALL PATIENTS MUST COMPLETE OUR "PATIENT INFORMATION FORM" BEFORE SEEING DR. GMITRUK
- FULL PAYMENT IS DUE AT TIME OF SERVICE.
- WE ACCEPT CASH, CHECKS, VISA, AND MASTERCARD
- BALANCES OVER THIRTY DAYS AFTER COMPLETION OF TREATMENT WILL REFLECT A 1% SERVICE CHARGE WITH A MINIMUM CHARGE OF \$5.00 PER MONTH

REGARDING INSURANCE:

INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. WE ARE NOT A PARTY TO THIS CONTRACT, ALTHOUGH WE WILL HELP YOU RECEIVE MAXIMUM BENEFITS. AS A COURTESY TO YOU, AS OUR PATIENT, WE WILL BE HAPPY TO FILE YOUR INSURANCE CLAIM FOR YOU. (AS LONG AS WE HAVE THE INFORMATION NEEDED. I.E. POLICY NUMBER, SOCIAL SECURITY NUMBER, EMPLOYER NAME AND ADDRESS, AND WHO AND WHERE TO SEND YOUR CLAIM.) THE INSURANCE COMPANY WILL REIMBURSE YOU DIRECTLY. PAYMENT IS REQUIRED AT TIME OF SERVICE.

THANK YOU FOR UNDERSTANDING OUR FINANCIAL POLICY. PLEASE LET US KNOW IF YOU HAVE ANY QUESTIONS OR CONCERNS.

RESPONSIBLE PARTY SIGNATURE _____