

OUR FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you read and sign prior to any treatment.

ALL PATIENTS MUST COMPLETE OUR INFORMATION FORM BEFORE SEEING THE DOCTOR.

FULL PAYMENT OF DUE AMOUNTS MUST BE PAID AT TIME OF SERVICE.
WE ACCEPT CASH, CHECKS, OR VISA/MASTERCARD/DISCOVER.

Regarding Insurance

We will file and accept assignment of insurance benefits as a convenience to you. However, the balance is your responsibility, whether your insurance company pays or not. We cannot bill your insurance company unless you give us your timely updated and correct insurance information. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Please be aware that some, and perhaps all, of the services provided may be non-covered services, and/or not considered reasonable and necessary under your insurance plan. You will be responsible for contacting your insurance company prior to your scheduled appointment to obtain benefit information. Some insurance policies do not cover in-house labs with well exams. These labs will be optional to you. If they are not covered by your insurance you will be responsible for the balance.

Usual and Customary Rates

Our practice is committed to providing the best treatment for our patients, and we charge what is usual and customary for our area. Any balance not paid by your insurance company for well child care physicals, including immunizations, must be paid in full before the next scheduled appointment. All required health forms filled out by us at the time of the visit will be done at no charge, for the forms filled out at a later time we shall charge \$5 each.

Missed Appointments

Unless canceled at least 24 hours in advance our policy is to charge for missed appointments at the rate of a normal office visit. All no-shows will be noted in the patient's chart. Two (2) no-shows will constitute dismissal from this practice.

Medical Records

Any medical records brought or mailed to our practice from another Dr's office will become property of The WOP. If in the future you should leave our practice we will gladly forward a copy of your child's medical records to a Pediatrician of your choice. It is the policy of this office to charge for medical records release.

X _____ Date _____ 200
Signature of Patient or Responsible Party

X _____ Date _____ 200
Signature of Co-Responsible Party