Creekmore Clinic
Financial Policy

Patient Name:_____DOB:_____

Dear Patient:

Thank you for choosing us as your health care provider. The following is our Financial Policy. Our main concern is that you receive th proper and optimal treatment needed to restore your health. IF YOU HAVE ANY QUESTIONS OR CONCERNS ABOUT OUR PAYMENT POLICIES, PLEASE DO NOT HESITATE TO ASK OUR FINANCIAL COUNSELOR.

We ask that all patients read and sign our Financial Policy prior to receiving services. Payment for non-covered services is due at the ti services are rendered. I understand that the clinic will set up arrangements for payment of my account if I need this assistance. Cash, checks, Discover, Visa and Mastercard are accepted.

1. Your insurance policy is a contract between you, your employer, and the insurance company.

2. All charges are your responsibility whether your insurance company pays or not. Not all services are a covered benefit in all contracts. Some insurance companies arbitrarily select certain services they will not cover.

3. Fees for these services or co-payments are due at the time of service.

4. If the insurance company does not pay your balance in full within 30 days, we ask that you contact the carrier to help in processing your payment.

5. If the insurance company does not pay in full within 45 days, we require you to pay the balance due with cash, check, Discov Visa, or Mastercard.

6. Returned checks are subject to a $10.00 service fee and an immediate referral to an outside collection agency.

7. We will refund any credits on your account to you or your insurance company depending on the circumstances. However, if y have another account balance, any credit will be transferred to the account with the balance.

8. Financial Responsibility
   I/We the undersigned, jointly and severally, in consideration for the services rendered, accept financial responsibility and ag to pay the clinic for its charges for services rendered to the patient upon receipt of a statement for such charges. The undersig further agree that if such indebtedness is placed in the hands of a collector or an attorney for collection, the undersigned will reasonable collection fees and attorney fees, interest, court cost and other collections costs and expenses. I further authorize overpayment due me on this account to be applied to any other outstanding balance that I may owe at Creekmore Clinic.

9. Assignment of Insurance Benefits:
   I transfer and assign to the clinic and to any applicable physician(s), all of my rights to benefits payable to me or to a beneficiary. By this assignment, I authorize payment directly to the clinic and directly to the physician. I understand and agr that if any part of my account is not paid by insurance, for whatever reason, I am still financially responsible for the indebted It is my responsibility to take the action necessary for such benefits to be paid to the clinic or the physician(s).

Again, thank you for choosing us as your health care provider. We appreciate your trust in us and we appreciate the opportunity to se you.

Responsible Party Signature: X_____Date:_____

Witness:_____Date:_____

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