INSURANCE INFORMATION

Financial policy

Name of insured:_____relationship to insured _____
Date of Birth of insured:_____Name of Ins Co._____
Member ID/SS #_____ Group:_____
Name of responsible party:_____

Your insurance company is a contract between you and your insurance carrier. We are not a party to that contract. We may accept assignment of insurance benefits after we have proper verification. **The fees and co-payments for most plans are established by your insurance company.** The co-payments and deductible must be paid at the time of service. The balance is your responsibility whether or not your insurance company pays **after (90)days.**

Please keep in mind that some procedures have restricted frequencies as to how often they can be performed. As a courtesy, we will call your insurance company so that we can estimate the insurance portion and the patient portion of charges to the best of our expertise. This is an approximate computation of probable cost and does not guarantee payment from your insurance company.

I have read and understand and agree to the terms of financial policy.

Signature of responsible party:_____ Date:_____