

Office Financial Policies

It is the policy of this office to help keep your healthcare costs as low as possible. In order to do this, we need to keep our billing costs to a minimum. Please help us in the following ways:

1. Always bring your current health insurance card to your office appointment.
2. Please notify us at check-in of any changes in Insurance, address, phone #, etc.
3. Co-pays, coinsurance and/or deductible is due at the time of service; or, if you do not have health insurance, please come prepared to make an initial payment of \$35.00 for your visit. All Health Saving Accounts will also be required to make an initial \$35.00 payment at the time of service.
4. Please make sure, prior to your visit that you have obtained the proper referral and/or authorization from your insurance company for the visit. You are responsible for obtaining all required referrals and authorizations that are required from your primary care physician. Please check with your insurance company if a referral is needed for your visit with our practice/doctor.
5. Please make sure with your plan as to the participation status of the physician you are seeing. We will not deny care to any patient due to uncertainty as to participation level of our physicians with your Insurance plan, but please understand you are responsible for verifying this information with your carrier.
6. You should receive a bill for any patient responsibility within 30 - 45 days, and/or an explanation of benefits from your carrier. If you do not, please contact the billing office at 513-841-0037. All unpaid bills past due beyond 90 days will be sent to an outside collection agency unless alternative payment arrangements have been made with our office.

We will file all Insurance claims for you; however, the ultimate responsibility for payment is yours.

There will be a \$35.00 fee for returned checks.

Insurance Release:

This is to certify that I have been informed prior to receiving treatment today that my health plan may not be liable for services rendered if any of the following conditions apply:

- Provider not participating in my health plan
- Unmet deductible under my health plan contract.
- Services may not be covered under my health plan
- I may not have obtained the proper authorization and/or referral for my treatment

Therefore knowing this, I request that services be performed and I agree to be responsible for any charges incurred.

I have read the above and agree to my financial responsibility as outlined above and understand that I am ultimately responsible for all the charges incurred by me.

Patient/Member

Date of Birth

Date