Print Form

Mallory Osteopathic family practice
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FINANCIAL AGREEMENT

We will be happy to file your insurance claims for you. You understand that the following conditions apply:

- You accept responsibility for providing us with a current valid insurance card for the purpose of identification and verification of your insurance coverage.
- Your insurance co-pay is due at the time of service. If you are receiving multiple treatments during a week (e.g. traction therapy), you may make one payment for all co-pays at the beginning of that week. Otherwise, you may pay your co-pay on a daily basis.
- **You are responsible for paying the outstanding balance on your account before seeing a provider.**
- **You understand that you are responsible for any portion of your bill that your insurance company does not pay**.
- If your claim is denied because of lack of coverage or because your insurance company does not pay for the service rendered, you will be responsible for the entire balance on your account.
- You understand that regardless of the type of insurance coverage you may have, policies are a contract between yourself and the insurance carrier.
- You understand that services rendered you are charged directly to your account and that you are ultimately responsible for payment.
- Accounts more than 90 days past due will be considered for collections processing and any legal/collection fees incurred will be your responsibility. There is a $5.00 fee added to your account each time we must rebill for outstanding balances.
- We require a 2 hour notice for cancellation of appointments. If you fail to give proper notice to cancel your scheduled appointment, you will be charged $50.00.
- We accept cash, Visa, MasterCard, Discover, American Express and personal checks. Any returned checks will be assessed a $20.00 fee. The amount of the check and the fee are to be repaid within two weeks. If two checks are returned, we will no longer accept check payments, and you will be required to provide cash or credit card payments brought directly to our office.

I acknowledge that by signing this financial policy, I understand and agree to all of the stated conditions as they apply.

_____ _____
Patient/Guardian Signature Date

_____
Print Name