

Credit and Payment Policy:

It is our goal to provide you the best medical care we possibly can. Part of your care includes the billing of your insurance provided; we've received the correct and complete information from you. If complete information is not provided at the time of your visit, you will be billed. Please review our updated office policies regarding appointments and financial responsibilities:

- ❖ **Patient Requirements:** All patients are expected to present a current insurance card and a valid photo ID at the time of service. Payment for co-pays, co-insurance, and any outstanding balances is required at check-in.
- ❖ **Co-pays:** Both primary and secondary insurance co-pays must be paid at the time of check-in.
- ❖ **Collections and Balances:** Optimum Point of Care does not permit patients to carry outstanding balances. Patients with unresolved balances may be sent to collections and assessed an additional 35% collection fee. All balances must be resolved before scheduling future appointments. Failure to address these balances may result in discharge from the practice.
- ❖ **No-Show Fees:** Cancellations must be made at least 48 hours in advance. Failure to cancel within this window will result in a \$50.00 fee for standard appointments and a \$75.00 fee for diagnostic studies (such as echoes or general ultrasounds).
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Please note that confirmation calls are a courtesy provided by this office and not an obligation. Therefore, the lack of a confirmation call will not be considered a valid reason to waive a no-show fee.

Assignments and Releases:

I have read, understand, and agree to the Financial Policy stated above. I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibility. I also agree to contact my insurance carrier(s) if they do not respond to payment requests made on my behalf.

Patient / Responsible Pary Signature: _____ **Date:** _____

I understand and agree that I am personally responsible for all charges incurred regardless of my insurance coverage. In the event that my account is referred to a Collection Agency, I agree that any fee in addition to the balance owed. Payment for the services rendered or to be rendered in the future is irrevocably and unconditionally guaranteed by Guarantor who signature appears below together with interest thereon and all late charges fees cost and expenses of collection incurred in enforcing any of such liabilities.

Patient / Responsible Pary Signature: _____ **Date:** _____

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Office use only:

Account Num: _____

Date: _____