PATIENT FINANCIAL RESPONSIBILITY

DR. DAN BANGART DR. KEITH BANGART DR. JEFF THOMAS DR. SHANE MOORE

As a **courtesy** to our patients, we have enrolled in numerous managed care insurance programs. We are pleased to be able to provide this service to you, and we will make every effort to verify coverage and bill your insurance company correctly. However, it is not possible for us to keep track of all the individual requirements of each plan.

It is the responsibility of each patient to notify our office of any changes to their demographics/insurance coverage, and to know the details of his/her insurance plan. Any charges that occur because of insurance plan restrictions or lapses in coverage are ultimately the patient's responsibility. Unfortunately, if you do not inform us of special requirements required by your plan and we order medically necessary service, such as lab work, x-rays, orthotics or supplies, not covered by your plan or should hit your deductible; we may bill you directly for those charges. If current coverage cannot be verified, prior to each appointment, payment will be due at the time of service. Payment of co-pay's are required prior to services being rendered. Any patient responsibility that is not paid within 30 days from the date billed may be assessed a 2 ½ % interest of the total amount due, per month. After 90 days of non-payment, your account will be subject to collections. You, as the patient, will be responsible for all collection charges.

Providing the highest quality of medical care for our patients is our primary concern. We are more than willing to provide the care within your insurance guidelines, whenever possible. With cooperation, you should be able to receive all the insurance benefits you are entitled to, and we will be able to focus our efforts on striving to provide you with excellent medical care.

BY SIGNING BELOW, I ACKNOWLEDGE I HAVE READ AND UNDERSTAND THE FOLLOWING POLICIES AND I ACCEPT THE RIGHTS AND RESPONSIBILITIES WITH THEM:

- **Patient Rights Regarding Medical Records**
- **HIPAA-Confidentiality and Privacy of Medical Records**
- **Patient Financial Responsibility**

I hereby authorize the physician to release any and all information necessary concerning my diagnosis and treatment for the purposes of securing payment from my insurance company and there by authorize payment of the insurance benefits directly to the physician for any services rendered that are not paid for directly by me.

______________________________	______________________________
PATIENT NAME (print)	Date
______________________________	______________________________
PATIENT SIGNATURE	NAME/RELATIONSHIP (If signed by other than patient)

**Copies of each policy available upon request.