FINANCIAL DISCLOSURE AND AGREEMENT

Patient Name *

First Name Last Name

Date of Birth *

Please initial next to each section

PROOF OF INSURANCE:

Your insurance card(s) and a picture ID should be brought to each appointment. It is your responsibility to inform the front desk of any changes in address, phone number or employment and when your insurance plan changes so that the correct plan is billed for your visit. Failure to provide requested information within 30 days of the visit will result in the claim(s) becoming the patient's responsibility. It is also your responsibility to know what your benefits are and if we are a participating provider on your plan.

Account balances must be paid in full prior to being seen and/or refill requests granted and processed.

We feel it is important for our patients to have an understanding of our financial policies and how they may be affected by them. Please ask questions regarding this document before you leave the office today. We are more than happy to assist you!

Patient signature * Date *