

Financial Policy & Statement

- **If you do not have insurance or you have insurance other than BCBS:** All payments are expected at the time of service or by a mutually agreeable payment plan. You will be provided with a super bill to submit your claim to your respective insurance plan.
- **If you have BCBS:** All deductibles and co-payments are expected at the time of service or by a mutually agreeable payment plan. We bill Blue Cross Blue Shield plans if proper paperwork is provided to us.
 - ***If your carrier has not paid a claim within sixty (60) days*** of submission, you agree to take an active part in the recovery of your claim in which our billing office will notify you of this need, and will help you navigate the process. If your insurance carrier has not paid ***within ninety (90) days*** of submission, you accept responsibility for payment in full of any outstanding balance and authorize us to use your credit card, debit card, or ACH bank withdrawal information on file to collect payment in full.
 - Our fees are considered ***usual, customary and reasonable*** by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.
 - ***Non-covered services:*** Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.
 - ***Yearly health checks:*** Periodic preventive health checks may or may not be covered under your health insurance policy; however, your physician or employer may require them.
- **For all patients:**
 - ***Missed appointments:*** In fairness to other patients and the doctor, we require at least 24 hours notice to cancel appointments. You will be charged the cost of the visit for missed appointments.
 - ***Discontinuation of care:*** If you discontinue care for any reason other than discharge by your provider, all outstanding balances will become immediately due and payable in full by you.
 - ***Returned payments:*** If a payment is returned by your bank or creditor or unpaid for any reason, we reserve the right to automatically withdraw that payment in full by electronic funds transfer from the account or the credit account we have on file, along with an additional fee of \$30.00. Any and all financial information provided by you will be protected as part of your Personal Health Information and additionally protected under federal HIPAA regulation and therefore subject to a \$10,000 fine to anyone who misuses this information.

Assignment of Insurance Benefits – INSURANCE PATIENTS please read and sign below.

I hereby assign all medical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans, to **Dr. Katie Gregory**. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signature: _____ **Date:** _____

ALL PATIENTS please sign: I have read, understood and agreed to the above financial policy for payment of professional fees. I understand I am ultimately responsible for all professional fees.

Signature: _____ **Date:** _____