INSURANCE BILLING: Payment is required at the time of treatment, however as a courtesy, in most circumstances, we will bill your insurance company. It is your responsibility to contact your insurance company to learn more about your benefits and how they will apply to your treatment and care. If your insurance company does not pay your account per the contracted fee schedule, the balance will be transferred to you or the guarantor listed on the Patient Information form. If you are unable to make payment in full, please contact the billing department immediately to make payment arrangements.

I. **HMO PLANS** (With Which We Are Contracted): All co-pays must be satisfied at every visit. Due to contractual and uniform compliance issues with your insurance company, there are no exceptions to the policy of collecting copays at every visit.

II. **PPO PLANS** (With Which We Are Contracted): We have negotiated rates with your insurance company. Your coinsurance and unmet deductible is your responsibility and payment is due at time of treatment.

III. **OTHER PPO PLANS** (With Which We Are Not Contracted): In the event your insurance coverage changes to a plan where we are not a participating provider, you will be responsible for any out of network deductible or coinsurance amounts should you have out-of-network benefits. Please contact your insurance company prior to treatment to ensure that you obtain the best possible care covered by your policy.

IV. **MEDICARE**: We accept assignment with Medicare. Medicare pays 80% of the allowed amount after satisfaction of the annual deductible. We will bill your secondary insurance for the remaining 20% of the Medicare allowed payment as a courtesy; however, you are responsible for any remaining balance regardless of payment from a secondary insurance.

V. **MEDI-CAL**: We are not a Medi-Cal provider. We are a CareOne provider through Greater Newport Physicians only. Any patient that sill wishes to be seen will be treated on a cash basis only. We cannot and will not bill any other Medi-Cal plan.

I hereby acknowledge that I have had an opportunity to review and have received a copy of the above Financial Policy. I further acknowledge that a copy of the Financial Policy is posted in the reception area.

Patient Signature: _____ Date: _____