



**FINANCIAL POLICY STATEMENT**

- We do our best to verify your insurance as a courtesy to you. However, it is not a guarantee of payment. Co-pays will be collected at the time of services are rendered. If you have co-insurance or a deductible, a bill will be sent to you for prompt payment. **Due to the fact that benefits are determined at the time the claim is processed, when payment from your insurance company is received, we will know then if it is necessary to modify your co-pay amount; or the amount to bill you or your co-insurance or deductible.**
- Be advised if you claim worker’s compensation benefits and are subsequently denied such benefits, you may be held responsible for the total amount of charges for services rendered to you.
- If any payment is made directly to you for services billed by us, you recognize your obligation to promptly remit the same amount to Advanced Injury Treatment Center.
- If you pay by check and your check is dishonored or returned for any reason, we will expect payment in full plus a returned check fee within 30 days of the returned check.
- I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, I will be responsible for all costs of collecting monies owed, including court costs and attorney fees.
- There is a **\$40.00** fee for all missed, broken or rescheduled appointments without 24 hour advance notice.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**BENEFIT ASSIGNMENT**

I, hereby assign all medical benefits to which I am entitled, including private insurance and third party payers to Advanced Injury Treatment Center.

Signature \_\_\_\_\_ Date \_\_\_\_\_