



**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 and deductibles will be collected at the time services are rendered. If you have co-insurance or a deductible, a bill will be sent to you for prompt payment of any balance due. **Due to the fact that payment is determined by your insurance carrier at the time the claim is processed, only when payment from your insurance company is received will we know if it is necessary to modify your co-pay amount, and only then will we know the amount to bill you for your co-insurance or deductible balance.**
- If your insurance plan requires that you need a doctor’s referral prior to treatment, **we must be in receipt of this referral before we can begin your care.** In the event of any unauthorized charges as deemed by your insurance carrier for lack of proper referral, you accept responsibility for payment of those claims.
- It is your responsibility to immediately notify us of changes to your insurance before and during your care. Any treatment provided that is not paid by your insurance because we were unable to obtain prior authorization because we did not have current insurance information is ultimately your financial responsibility.
- 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 of \$25 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 for services rendered.

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