



FINANCIAL POLICY

We are committed to providing the best treatment possible for our patients. Our charges are usual and customary for our specialty. Your insurance is a contract between you and your insurance company. You will be billed for any applicable copayments, deductibles, and/or exclusions of your insurance contract and it is your responsibility to know your plan's coverage, restrictions and requirements. Full payment is collected at the time of service for all co-pays, co-insurance or any deductible amounts. We accept cash, check, Visa, MasterCard and Care Credit. You are encouraged to inquire about the cost of any procedure before it is performed.

- Contracted insurance companies: BlueCross/BlueShield, Allegiance, New West, Medicare, Medicaid & Tricare.
- If your insurance determines a service non-covered, you will be responsible for the balance. If your insurance company has not settled a claim within 60 days, the responsibility for the balance will transfer to the patient.
- Montana Medicaid requires authorization from your primary care physician. Without this information, your appointment will be rescheduled or you will be required to sign a waiver and pay in full at the time of service.
- Patients without insurance coverage will be required to pay in full at the time of service. A 10% discount is available to self-pay patients when visits are paid in full at the time of service.
- If you require surgery, a patient representative will provide you with the estimated fee and explain your expected financial obligation. We require payment of your expected financial obligation prior to the procedure.
- When a patient is late, or does not arrive for an appointment, it prevents us from seeing and treating other patients in a timely manner. If you are running late, or are unable to make the appointment, please notify the office. If you do not inform our office that you will be unable to keep your appointment, you may be discharged from our practice.

MINOR PATIENTS: (under the age of 18) We assign all financial responsibility to the parent/guardian that completes and signs the patient registration forms. Any amount due at the time of service is expected from the parent/guardian accompanying the minor at the visit. Minors without a parent/guardian will be rescheduled.

PLEASE NOTE: Our office will charge \$15.00 on returned checks. Unpaid patient balances ≥ 60 days are subject to a yearly 9.5% interest rate of outstanding balances. If it becomes necessary to send your account to collection for non-payment, you will be responsible for all collection and legal fees incurred.

We feel it is important for our relationship that you understand our financial policies. Please read this carefully, and ASK IF YOU HAVE ANY QUESTIONS.

By signing the acknowledgement in the office, you are indicating that you have read and understand the above policies and had all your questions answered.

Signature: _____ Printed Name: _____ Date: _____
Relationship to Patient: _____