

Please read the following information very carefully. **A SIGNATURE IS REQUIRED OF ALL PATIENTS.** This information is provided to avoid any misunderstandings. Please ask a staff member if you have questions about our policy or would like to obtain a copy for your personal records.

**PAYMENT POLICY**

Payment is due in full 60 days after insurance response. If you have no insurance coverage or no insurance has been filed, payment is due 60 days after the date of service. If no payment has been received after 60 days, the account will be forwarded to our collection agency. Uninsured (Self pay) patients will be required to remit full payment for the initial visit to establish an account.

**FINANCIAL ARRANGEMENTS**

If you are experiencing financial hardship, contact us immediately. You may arrange a payment plan with our office. If a payment arrangement is in place, we must receive payment every 30 days. If no payment is received on the outstanding account after 60 days, your account will be forwarded to our collection agency.

**INSURANCE DISCREPANCIES**

It is the patient's responsibility to provide our office with **correct** Insurance information so that we may file claims efficiently. Our office files primary Insurance as a courtesy to our patients. If you feel that your Insurance Company has incorrectly denied a claim or that the Explanation of Benefits (EOB) is incorrect, you must contact the Insurance Company. The Insurance is a contract between the patient and the Insurance Company. We obtain our information directly from the Explanation of Benefits (EOB) and manage patient accounts accordingly. Any discrepancies must be handled by the patient by calling the Member Services number provided on their Insurance card. All patients must adhere to the above financial policy during any dispute with their insurance company.

**SECONDARY INSURANCE**

Patients are encouraged to contact their primary Insurance carrier to set up an automatic cross over to their secondary Insurance. Our office files secondary insurance only when mandated by Medicare (As the primary carrier). As a courtesy, we will provide you with the HCFA 1500 claim form to assist you in filing for your secondary coverage. You may request an Explanation of Benefits from your primary Insurance carrier to send along with the HCFA form.

**BILLING ERRORS**

If you feel that a billing error has been made, you must notify us immediately. You may contact us at (615) 494-1234. We will work to make sure that the account is corrected accordingly.

**INCORRECT PATIENT INFORMATION**

Please notify our office of any changes in insurance, address or telephone information. If the account is past due and we are unable to contact you via mail or telephone, the account will be turned over to our collection agency.

**PAYMENT TYPES**

Our office gladly accepts cash, personal checks, and money orders.

**AGREEMENT/SIGNATURE**

I, the undersigned, hereby agree that, in the event of default in the payment of any amount due, and if my account is placed in the hands of a collection agency or attorney for collection or legal action, to pay any additional charges incurred in the collection process.

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**Patient Signature/Parent Signature**

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**Date**

