



9 North Randolph St.  
Lexington, Virginia 24450  
(540) 464-4100

5012 Plantation Road  
Roanoke, Virginia 24019  
(540) 464-4100

## FINANCIAL POLICY

*The purpose of this policy is to help ensure patients can afford to receive the quality of care they desire. It is our intention that costs be covered, as much as possible, by the patient benefiting from the service provided.*

**PAYMENT IS DUE AT THE TIME SERVICES ARE RENDERED.** *Cash, checks, and Mastercard and Visa credit cards are accepted. Returned checks and outstanding balances older than 30 days, may be subject to a rebilling fee and/or bank charges. You will be asked for Mastercard/Visa information to hold your first appointment. The credit card will only be charged if the appointment is cancelled with less than 48 hours notice.*

As a medical provider, we must emphasize that our relationship is with you, not your insurance company. You are responsible for filing for reimbursement with your insurance company. Your receipt will include the medical diagnostic and treatment codes your insurance company will require to process your claim.

Unlike many medical providers, we schedule only one patient for each appointment slot *and* we allot a full hour for each appointment (2 hours for a new patient), including administrative time, to ensure your medical needs are well served. If you must cancel an appointment, please notify us as soon as you can (leave a message if the office is closed) so that we have a greater chance of being able to serve another patient. You will be charged your full appointment fee for missed/cancelled appointments unless you provide at least 24-hour notice, (48 hours for your initial appointment).

This office does *not* participate in patients' litigation – Medicaid, Social Security/disability, motor vehicle or other accidents. This office will **NOT** be available or required to give opinions in reference to your condition including, but not limited to, depositions, hearings, testimony, and/or trials.

Correspondence services, such as copies of medical records, letters, forms, and phone calls with you, or on your behalf, may be performed upon your request or as required for your care. You, or the receiving party, will be billed for such services.

If you do not have any questions concerning the above policy, please sign the statement below and bring it with you to your initial appointment.

***I understand and agree that, regardless of my insurance status, I am ultimately responsible for my account for any professional services rendered. I have read, understand and agree to all the information aforementioned, and have provided all information requested of me. I also certify this information to be true and correct to the best of my knowledge and belief, and understand it is my responsibility to notify your office of any change in my health or personal information. I authorize release of my medical and personal information as needed to facilitate my care.***

**Printed Name:** \_\_\_\_\_

**Signature:** \_\_\_\_\_

**Date :** \_\_\_\_\_