PAYMENT POLICIES
SIGNATURE MEDICAL GROUP

We accept cash, check, debit, Visa, MasterCard and most health plans/insurance programs. You may consent to pay by automated payment card by signing a separate authorization.

If the patient is covered by insurance, the following apply:

1. **The patient/responsible party or guarantor signing below ("you") must provide us with the patient's current and correct medical coverage/insurance/health plan ("health plan") or other responsible third-party payor.**
2. **You must follow the rules of the health plan such as providing a valid referral form and precertification of testing and/or surgery when required by the health plan for payment. We will assist with this process, but if claims are denied because of your failure to comply with coverage/payment rules, you will be responsible for paying the denied claim(s).**
3. **You are responsible for paying any deductibles and co-payments in the amount specified by the health plan as well as non-covered services or other costs not covered by the health plan.**
4. **Co-payments, non-covered services and other point of service payments must be paid at the time of service including amounts due for a child regardless of who has the legal obligation, or payment obligation under parental custody, divorce or separation terms.**
5. **WORK RELATED INJURIES:**
    a. **If the patient's employer has approved treatment, you will not be charged or billed.**
    b. **If the patient's employer does not approve treatment and <u>YOU SELECT US FOR YOUR TREATMENT</u>, you may be billed and you may be responsible for payment of services not approved by the employer.**
6. **If the patient is involved in a claim or lawsuit that affects the payment of our services, we hold you responsible for payment of our regular fees.**
7. **We file group health plan claims and by law, must file Medicare claims.**
8. **If you think your bill contains an error or if you need more information about an item on your bill, contact us at the address or telephone number on your statement.**

We expect payment in full at time of service for all charges which are not covered by the patient's health plan. It is your responsibility to contact us in the event of a need for an alternative payment plan or to apply for a discount if you do not have insurance.

In the event of non-payment, you will be responsible for any legal and collections fees. Legal and collection fees will be added to the outstanding balance on the account should the account be referred to an outside agency for collection.

I have read and agree to the above terms and hereby assume full responsibility for paying any medical service charges and collection fees according to these terms.

Print Patient Name: _____/Date of Birth: _____

Print Guarantor Name & Relationship to Patient: _____

Signed: _____/Date: _____
Patient or Guarantor/Responsible Party, if other than Patient

(Witness to Signature, if applicable): _____