# FINANCIAL AGREEMENT

Thank You for choosing John M. White DPM, as your health care specialist. The following is a statement of our Financial Policy, which we require that you read and sign prior to any treatment or office visit.

**DEDUCTIBLES, CO-PAYS AND ANY UNCOVERED SERVICES ARE DUE AT THE TIME OF SERVICE.**

WE ACCEPT CASH, CHECKS OR CREDIT CARDS.

It is your responsibility to provide the receptionist with your most current information. You will be required to provide a copy of your insurance card upon each visit and notify us immediately if any information has changed. Also, notify us of any address or phone number change.

**INSURANCE POLICY:**

Your insurance coverage is a contract between you and your insurance company. As a courtesy to you, we are happy to file your insurance for you. However, you are responsible for paying all co-payments, deductibles and non-covered services. We are not a party to the contract between the patient and their insurance company and have our own contractual obligations with each of the insurance companies we participate with.

In the event of assignment of benefits, you are still ultimately responsible for all charges. If you insurance company has not paid your account in full within 45 days, it is your responsibility to contact your insurance regarding your claim and notify our billing department of the status.

In order to provide you with the highest quality of service, while keeping our billing cost low we offer paperless billing by maintaining your credit card number on file to satisfy co pays, deductibles or balances not covered by your insurance. By signing this financial agreement you authorize Dr. White to maintain your credit account on file for billing purposes.

**MEDICARE POLICY:**

We accept Medicare assignment on all Medicare claims, and will file one secondary claim for you. You must provide us with the **current** and **correct** information at the time of your visit. Please notify us if your Medicare insurance is primary or secondary.

**Please sign below that you have read and understand our Financial Policies.**

**Patient Name**_____**date**_____

**Signature**_____(Patient/Guardian)