William A. Hamilton, M.D. F.A.C.O.G.

FINANCIAL POLICY

Thank you for choosing this office as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy, which we require you read and sign prior to any treatment.

Our self-pay patients are required to PAY IN FULL AT TIME OF SERVICE. All Copays are due at time of visit. We do not bill for Copays.

We accept most insurance plans. If your insurance carrier is one that we do not participate with we will be happy to file on your behalf. However, any services not covered will be the patient's responsibility. Your insurance is a contract between you and your insurance company. We are not a party to that contract.

Patient is responsible for providing this office with up to date insurance information in order for us to file your claim. Payment is considered past due 30 days after the insurance company has addressed the claim. If the insurance has not addressed your claim after 30 days, we will rebill it. If we get no response from the insurance company, the balance will then become the responsibility of the patient.

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

We reserve the right to charge interest on delinquent accounts as provided by state law. I have read and understand the financial policy and agree to abide by this policy.

X_____ Date_____
Signature of Patient or Responsible Party