Empirical Grace – Financial Agreement

As a courtesy to our patients, we will bill your insurance company. Benefits will be assigned directly to this office. YOU ARE RESPONSIBLE to know what your insurance covers prior to seeing us. As a courtesy we may call on your behalf. Although it is not a guarantee of payment, we will provide the information received to you.

To prevent any misunderstanding about insurance coverage benefits and our billing/collections procedures, we wish to inform patients that services cannot be rendered on the ASSUMPTION all charges will be paid by your insurance company. You will be fully responsible for all professional services rendered if your insurance company does not pay.

It is the policy of this office to:

1. Collect full payment of services rendered at the time the services are rendered.
2. Payments made by your insurance company are sent directly to you.
3. Appointment Cancellation Policy: A $30.00 fee may apply if less than 24 hours' notice is given.

By signing this form, you acknowledge receipt of the above information regarding your insurance and are aware that we will be sending all claims to your insurance company and you give us permission to do so. Your signature will signify your understanding and compliance of Empirical Grace office policies.

Signature: _____

Date: _____