GUIDINGSTAR tampa

Together, Building a Culture of Life!

Financial Policy

We are dedicated to providing the best possible care for you, and we want you to completely understand our financial policies.

1. Payment is due at the time of service unless you have insurance coverage. We accept cash, Visa, MasterCard, American Express and CareCredit.

2. Regarding using insurance:

    a. Keep in mind that your insurance policy is a contract between you and your insurance company. As a service to you, we will file your insurance claim if you assign the benefits to our practice – in other words, if you agree to have your insurance company pay us directly.

    b. If your insurance company does not pay the practice within 90 days, we expect payment from you. Therefore, at the time of service, **we require a credit card to be on file for all insured patients.** The transfer of the cost will be put on your credit card after 90 days. If we later receive a check from your insurer, we will refund any overpayment to you.

    c. We have made prior arrangements with many insurance companies and other health plans to accept assignment of benefits**. If you are required to pay a co-payment it is due at the time of service.** If applicable, coinsurance will be charged to your credit card on file after insurance claims are processed.

    d. Not all insurance plans cover all services. **In the event your insurance plan determines a service to be "not covered", you will be responsible for the complete charge.** Upon receipt of notification by the insurance company we will transfer the balance to your credit card on file.

    e. If you are insured by a plan that we do not have a prior arrangement with, we will prepare and send the claim for you as a courtesy of unassigned benefits. This means the insurer will send the payment directly to you. Therefore, our charges for your care are due at the time of service.

3. The practice reserves the right to bill you for any collection or attorney fees for unpaid debt.

4. The practice reserves the right to bill you for any appointment which is not cancelled 24 hours in advance.

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

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Signature of Patient (or Responsible Party) Date

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Print Name of Patient (or Responsible Party, include relationship to patient)