

**FINANCIAL POLICY: Insurance Assignment**

Dear Patient:

You have selected “Insurance Assignment” as the method of choice to take care of your financial obligation with this office. It is important you realize that our office offers the option of “Insurance Assignment” strictly as a courtesy to our patients, and as such, our patients understand and agree to the following:

1. **You are considered a cash patient until YOU qualify your insurance, and this office accepts your insurance coverage. It is YOUR responsibility to understand and track the limits of YOUR coverage (deductibles, # of visits, co-pays, etc.). Visits in excess of the limits of your insurance are your responsibility and will be charged directly to YOU . \_\_\_\_\_ (initial)**
  
2. **You are ultimately responsible for full payment for any and all services rendered.**
  
3. **You must pay all deductibles in full.**
  
4. **Co-pays must be paid at the time of services or by the end of the week.** Balances due beyond 30 days will result in a 1.5% finance charge, compounded monthly to 18% per year, plus a \$5.00 billing fee per bill per month.
  
5. **If the carrier has not paid a claim within 60 days of submission, you are responsible to take an active part in the recovery of your claim. After 90 days you will be responsible for payment in full for any outstanding balance. \_\_\_\_\_**
  
6. **Cancellation of appointments requires 24 hours notice** (exceptions: extreme weather and emergencies/illness). Otherwise, missed appointments are the full financial responsibility of the patient and will be charged directly to the patient at **\$40.00 per missed appointment in addition to a \$5.00 billing fee.**

Please sign this form as acknowledgement that you understand our financial policy and that you accept full responsibility for services rendered.

Print Name: \_\_\_\_\_

Sign: \_\_\_\_\_ Date: \_\_\_\_\_

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