Financial Policy

Dear Patient,

Thank you for choosing us as your health care provider. The following is a description of our financial policy:

1. Payment for services is due at the time services are rendered.
   - We accept cash, checks, Visa, MasterCard, Discover, and American Express.
   - We reserve the right to collect before services are rendered.
2. All charges are your responsibility whether the Insurance company pays or not.
   - Not all services are a covered benefit. Benefits may vary on different insurance plans. It is your responsibility to verify your insurance coverage.
   - Fees for non-covered services, deductibles, and co-payments are due at the time of treatment.
   - If your insurance company does not pay your claim within a reasonable time frame, or if coverage for a particular service/supply is denied, we may require you to follow up with your insurance and/or pay the balance due.
3. Unless you are Insured by Medicare or an insurance group which our doctors are participating members, or double insured for the procedure being performed, it is our policy to collect payment at the time the services are rendered.
4. If you are a member of an HMO or Managed Care Program or have a Primary Care Physician (PCP), you are responsible for contacting your PCP for a referral number prior to your visit if one is required by your insurance company.
5. We understand that temporary financial difficulties may affect timely payment of your balance. We ask that you speak with an Account Manager if you encounter such problems so that we may assist you in the management of your account. You may reach an Account Manager at 865-851-9822. Again, thank you for selecting us as your health care provider. We appreciate your trust in us and we appreciate the opportunity to serve you.

OFFICE USE ONLY

Primary Insurance Benefits

Copay $_____ Deductible $_____ Met $_____ Insurance Pays $_____

Secondary Insurance Benefits (if applicable)

Copay $_____ Deductible $_____ Met $_____ Insurance Pays $_____

Visit/Cap Limit _____ (per calendar year/policy year)

I agree to pay $_____ (per visit/per hour/package total.

_____ _____

Patient/Guarantor Signature Date

Witness Signature Date