

Office Financial Policies

It is the policy of this office to help keep your healthcare costs as low as possible. In order to do this, we need to keep our billing costs to a minimum. Please help us in the following ways:

1. Always bring your current health insurance card to the office.
2. Please notify us at time of check-in of any changes in insurance, address, phone number, etc.
3. Please pay your co-insurance or deductible at the time of service; or, if you do not have insurance, please come prepared to pay for your visit in full.
4. Please make sure prior to your visit that you have the proper referral and/or authorization from your insurance company for the visit.
5. Please make sure with your plan as to the participation status of the physician you are seeing. We will not deny care to any patient due to uncertainty as to participation status of your physicians with your insurance plan, but please understand you are responsible for verifying this information with your carrier.
6. You should receive a bill for any patient responsibility within 30 days, and/or an explanation of benefits from your carrier. If you do not, please contact the billing office at (513) 793-9600, extension 324 or 320.

We will file all insurance claims for you; however, the ultimate responsibility for payment is yours.

There will be a \$25.00 fee for returned checks.

Insurance Release:

This is to certify that I have been informed prior to receiving treatment today that my health plan may not be liable for services rendered if any of the following conditions apply:

- I may have a pre-existing condition or other diagnosis that may not be covered by my plan
- My insurance carrier may not have established medical necessity for this procedure/treatment
- Provider not participating in my health plan
- Unmet deductible under my health plan contract
- Services may not be covered under my health plan
- I may not have obtained proper authorization or referral for my treatment
- Certain supply items may not be covered by my plan

Therefore, knowing this, I request that services be performed and I agree to be responsible for any charges incurred.

I have read the above, agree to my financial responsibility as outlined above, and understand that I am ultimately responsible for the charges incurred by me.

Patient/Member _____ Date _____

Physician or Staff Member _____ Date _____