J. Brian Boyd M.D. Inc.
FINANCIAL POLICY

By signing below, I understand that I am responsible for payment of all services provided to me by J. Brian Boyd M.D. Inc. If I am not the patient, I understand that by signing below, I am personally responsible for all fees incurred by _____ (name of patient). I understand that I am responsible for payment whether there is any applicable insurance coverage or not.

I am responsible for any fees not covered by insurance. For those patients who are covered by insurance, J. Brian Boyd M.D. Inc. will bill your insurance as a curtesy, whenever medically applicable. Any co-pays, co-insurance and/or deductibles as specified by your insurance policy will be collected on the day of service.

We try to make every attempt to verify your insurance benefits prior to your appointment when provided with the appropriate information ahead of time. Verification of insurance is NOT a guarantee of coverage. Medical necessity is up to the determination of your insurance provider.

I understand that my insurance company will be billed, and the money paid by the insurance company belongs entirely to my provider. I acknowledge the possibility that checks may be sent directly to me instead of to my provider. I acknowledge that this money, no matter what amount, is not mine even though the checks may be written to me or to the subscriber of my health plan. I therefore agree to immediately forward any amounts I receive directly to my provider. I will make no attempts to negotiate what amount I send to my providers or to recover amounts they receive. Insurance payments cannot be applied to cosmetic procedures.

Any outstanding balances that is your responsibility will be expected to be paid in full within 30 days of notification. Any unpaid balances may be assigned for collection to a collection agency at any time at J. Brian Boyd M.D. Inc. sole discretion. If legal proceedings are started to collect any unpaid balance, I will additionally be responsible for any attorney fees and court cost incurred by J. Brian Boyd M.D. Inc. I have read and understood the above and I have no questions regarding payment terms.

Thank you,

Kristine Nickel
Office Manager
J. Brian Boyd, M.D., Inc.

_____ _____
SIGNATURE OF PATIENT/ PARENT OR LEGAL GUARDIAN OF A MINOR DATE