FINANCIAL POLICY & AGREEMENT FOR SERVICES

THE SHORE CLINIC is committed to providing you with the best possible care and we are open to discuss our financial fees with you at any time. We recognize payment for medical services can be confusing and complex given insurance coverage with deductibles and copayments. Please review and complete this agreement carefully so we can best serve your billing and payment needs.

INSURANCE: The Shore Clinic accepts a number of insurance providers. Please be sure to provide your insurance information with the clinic **DURING REGISTRATION.** You are responsible for providing all coverage information and establishing the primary, secondary, and co-insurance plans (if applicable) coverage at your initial session. We will accept and file your insurance if we are a provider on your plan. Note: Your insurance coverage is a contract between you and your insurance carrier. We encourage all clients to confirm their benefits with their carrier to ensure coverage and payment.

COPAYMENT AND DEDUCTIBLE PAYMENTS: It is likely that your insurance coverage includes responsibility for deductible payments and co-payments. All co-pays must be paid at the time of service. If your insurance coverage requires a deductible before your carrier will pay for services, you are responsible for a payment toward your deductible until it is paid. Once services have been established, if two sessions occur without receipt of payment you will need to submit the payment for the balance due or make payment arrangements with our office in order to continue services.

CO-PAY:

□ I currently have a co-payment of **$**_____ that I agree to pay at time of service.

DEDUCTIBLE PAYMENT:

□ I currently have a deductible of **$**_____ that has not been satisfied.
I agree to make a payment towards my deductible at each time of service.

FEE AGREEMENT:

□ I currently have a fee agreement with the Shore Clinic.
I have agreed to pay **$**_____ on the _____ of each month.
I have agreed to pay **$**_____ at time of service.

I understand that all payments are expected at the time of service. I further understand that services may be interrupted if I am unable to pay.

If any of this information is incorrect, please contact your insurance company via the number on your insurance card, or our billing department at 262-367-2476 x 310.

SIGNATURE: _____ **DATE:** _____

CLIENT'S NAME: (PRINT) _____ **DATE OF BIRTH:** _____

RELATIONSHIP (IF OTHER THAN CLIENT): _____