Interlachen Family Practice
John B. Hirt, D.O.
5542 Lake Howell Road Winter Park Florida 32792
Phone: 678-5554 Facsimile: 877-247-3082

FINANCIAL POLICY

Dr. John B. Hirt and Staff would like to welcome you to our Practice. We strive to provide you with excellent medical care and our goal is to make your visits as convenient as possible.

By signing below you confirm that you have read this policy and understand that:

* It is your responsibility to inform our office of any address or telephone changes.
* Your account is to be kept current — accordingly, all self-pay or insurance co-payment, co-insurance and deductibles will be collected at the time of service. Payable by cash, check, Visa, MasterCard or Discover.
* If you do have your payment(s) your appointment may be rescheduled.
* You may be asked to schedule another appointment for issues other than the reason for your original appointment.
* We reserve the right to charge for appointments cancelled or broken with 24 hours advance notice.

IF YOU HAVE HEALTH INSURANCE COVERAGE:

We will submit your claims, however, ***we must emphasize that as medical providers, our relationship is with you, not your insurance company.*** Although we attempt to verify your healthcare benefits with your insurance, please be advised this is only an estimate o your coverage based on the information given to us at the time of the inquiry.

By signing below you confirm that you understand:

* It is your responsibility to inform us of any changes to your insurance policy so that your coverage can be reverified prior to your appointment.
* Not all services are covered benefit with all insurance plans.
* It is your responsibility to be aware of what service(s) is being provided to you and if it is a covered benefit under your insurance policy.
* You are responsible for any non-covered charges not payable by your insurance policy.
* Although filing your insurance claims is a courtesy extended to you, all charges are always your responsibility from the date services are rendered.

We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we urge you to contact us promptly for assistance in the management of your account. If you have any questions about the above information, *please* do not hesitate to ask us.
We are here to help you.

I have read and understand the above Financial Policy and agree to meet all financial obligations.

_____	_____	_____
Patient Name (Print)	**Patient Signature**	**Date**
_____	_____	_____
Responsible Party (Print)	**Signature**	**Date**