4200 Little Blue Pkwy. Suite 350
Independence, MO 64057
816-648-6482 phone
855-618-2442 fax
www.miva-medical.com

Patient Financial Policy

We are committed to providing you with the best possible care, and will help you receive your maximum allowable insurance benefits. However, we need your assistance and your understanding of our payment policy. Your insurance contract is between YOU/YOUR INSURANCE COMPANY/YOUR EMPLOYER. (Please refer to enclosed document-"Understanding Your Insurance Coverage") Not all services are covered by all contracts.

We participate and accept assignment from most major payers, which means covered charges will be paid directly to us. If we do not participate in your insurance plan, you may still choose to be seen by the practice. As a courtesy to you, we will file a claim with your insurance carrier on your behalf. Any remaining balance will be billed to you once we have received a remittance from your insurance carrier.

Due to current federal and insurance regulations, ALL co-payments, co-insurance and deductibles are collected at the time of service. We accept Visa, American Express, MasterCard, and Discover and in certain situations will accept a personal check made out to our office. Additional fees, which typically are not covered by insurance plans, will be charged for services such as copying of medical records and completion of disability forms. A fee of $35.00 will be charged for checks returned for insufficient funds. An additional monthly fee may be charged on all past due accounts and co-pays not paid at time of visit. We encourage you to contact our **Billing Company** promptly for assistance in the management of your account. We are here to help you and will be happy to answer any questions you may have about your treatment or insurance coverage.

Patient Financial Agreement

I understand and agree that regardless of my insurance status, I am ultimately responsible for the balance on my account for ANY professional services rendered. I have read the above Patient Financial Policy and have provided the Practice with true and correct insurance information. I will notify you of any changes in my health insurance coverage.

_____ _____

Patient Signature Date

_____

Patient Name (printed)