

FINANCIAL POLICY

Please complete this form on your computer, print and bring to your appointment. OR, you may print and complete manually.



Acknowledgement of Financial Policy

Please be advised that you, the patient, are responsible for any procedures or office visits that are not covered by the insurance company.

We will submit all office visits and procedures to participating insurance companies. Certain procedures do need authorization. Please be aware that authorization does not guarantee payment.

I have read the above policy and I am aware that I am responsible for paying any balance on my account in a timely manner. Accounts that are not paid within 90 days may be sent to a collection agency. There will be a 15% charge added to your account for any collection or legal fees.

Patient Name (Please Print)

X _____ Date: _____
Signature of Patient (or parent, if minor)

1500 Horizon Dr., Ste 106
Chalfont, PA 18914
215.997.FOOT (3668)

700 W. State St.
Doylestown, PA 18901
215.348.4397

214 E. Pennsylvania Ave.
Oreland, PA 19075
215.572.6070

444 N. York Rd. Ste. A1
Hatboro, PA 19040
215.672.2111