DICKSON MEDICAL ASSOCIATES
FINANCIAL POLICY

Thank you for choosing Dickson Medical Associates (DMA) as your health care provider. The following is our financial policy. If you have any questions, please consult with a member of our office staff.

Cash/Non-Insured Patients may be eligible for a discount.

Insured Patients: Copays and deductibles are due at time of service. For your convenience we accept cash, checks, MasterCard, Visa, Discover, and American Express.

As a rule, we attempt to verify all benefits prior to your appointment, but in some cases this is not possible. It is ultimately your responsibility to verify with your insurance plan that Dickson Medical Associates is a participating provider, what your benefits are, and that you have active insurance and have supplied us with that information, when applicable. In the event that your insurance claim is denied, you will be responsible for services rendered.

If your insurance plan requires a referral, it is your responsibility to ensure that our office is in possession of the referral letter or number prior to your visit. If the referral is not made available to us by the time of your visit, you may choose to pay for the visit or reschedule your appointment.

From time to time, your insurance company may request further information from you before processing your claim. Failure to comply with this request in a timely manner may result in your claim being denied. In that event, you will be held responsible for the entire amount of the claim.

Return checks will be subject to a $30 fee.

Delinquent accounts will be turned over to an outside collection agency without notice. Accounts may be considered delinquent if unpaid after 60 days. In the event your account is turned over for collection, you will be responsible for all reasonable handling, collection, and court costs.

Please feel free to speak with our office staff or contact our business office at (615) 446-1365 with any questions. Additional information is available on our website at www.dicksonmd.com.

Again, thank you for choosing us as your health care provider. We appreciate your trust in us and we appreciate the opportunity to serve you.

Please indicate your understanding and acceptance of this policy by signing and dating below.

Patient's Name (please print):_____**Date of Birth:**_____

Signature:_____ **Relationship to Patient:**_____ **Date:**_____