**FINANCIAL POLICY**

ALL CO-PAYS OR DEDUCTIBLES ARE COLLECTED AT THE TIME SERVICES ARE PROVIDED.

YOUR OFFICE VISIT TODAY MAY NOT BE COVERED BY YOUR INSURANCE COMPANY.

AS A COURTESY WE WILL BILL YOUR INSURANCE FOR TODAYS SERVICES.

BASED UPON THE PROCESSING OF THE CLAIM, YOU MAY BE RECEIVING AN INVOICE FOR ANY REMAINING BALANCE.

IF YOUR INSURANCE COMPANY FAILS TO PAY WITHIN A 60 DAY PERIOD, YOU WILL RECEIVE A STATEMENT WITH THE EXPECTATION THAT YOU WILL FOLLOW UP WITH YOUR INSURANCE COMPANY. **THIS IS YOUR INSURANCE!** PLEASE CONTACT US IMMEDIATELY IF ANY ADDITIONAL BILLING INFORMATION IS NECESSARY. SERVICES THAT ARE DENIED, NON- COVERED, OR DETERMINED BY YOUR INSURANCE AS PATIENT RESPONSIBILITY, ARE TO BE PAID IN FULL TO DESERT BREEZE INTERNAL MEDICINE.

FOR YOUR CONVENIENCE THE OFFICE WILL ACCEPT PAYMENTS BY CREDIT CARD, CHECK, OR CASH.

I HAVE READ AND UNDERSTAND THE OFFICE POLICY OF DESERT BREEZE INTERNAL MEDICINE.

PATIENT NAME____________________________________ DATE_____________________

RESPONSIBLE PARTY SIGNATURE________________________________________________

**5111 N SCOTTSDALE ROAD SUITE 158 SCOTTSDALE, AZ 85250**

**(P) 480-949-7080 (F) 480-675-9145**