Patient Financial Policy

Thank you for choosing the Physicians Center for WellBeing as your health care provider. We are committed to building a successful physician-patient relationship for you and your family. It is the goal of The Physicians Center for WellBeing to provide the best care on your behalf. It is also our desire to assist you in the financial arrangements related to your care. Therefore, it is important for you to have a clear understanding of your patients' financial responsibility. Please understand that payment for services is part of that relationship. Please read the following information carefully and feel free to ask any questions you may have in any area. We ask that you sign this statement when you have read and understand each point covered.

Registration:

Upon registration, each patient is asked to complete our Patient Information Form, a Medical Information sheet, and a Financial Responsibility Waiver. We ask for a copy of your driver's license and copy of your insurance card. We also ask for your permission to take a photograph for your medical chart. Scanned copies of your insurance card and driver's license are part of your medical record. It is your responsibility to notify our office of any patient information changes such as address, name, telephone number and insurance information.

Guarantor

Any patient over the age of 18, or an emancipated minor, will be held financially responsible for all charges incurred. If another party is responsible for payment of your account, you must pay your balance in full and negotiate repayment with them outside of our office. This policy includes individuals negotiating divorce agreements.

Co-Payment

A patient is expected to present an insurance card at each visit. All co-payments and past due balances are due at the time of your appointment- unless previous arrangements have been made**. We accept, cash, checks or credit cards.** We also have a policy which enables our office to maintain your credit card information as well as your Health Saving or Flex Spending Card on file and process deductibles and outstanding balances that your insurance has processed and deemed your responsibility. **Please see the Credit Card on File Agreement for further information.**

Returned Checks

There is $ 35.00 fee for all checks presented for payment with non-sufficient funds (bad checks). **No postdated checks will be accepted.**

Insurance Claims

We verify coverage on the day of your appointment. If we cannot verify active coverage, your appointment must be rescheduled. It is your responsibility to know what your insurance benefits cover and if we are an in-network or out of network provider. Some plans also have tiered coverage.

If you have health insurance, this is an agreement between you and your insurance carrier to pay for medical care. In most cases, we are **not** a party of this contract. We will bill your insurance company as a courtesy. To properly bill your insurance company, we require that you disclose all insurance information including primary and secondary insurance, as well as, any change of insurance information. Failure to provide complete and accurate insurance information may result in patient responsibility for the entire bill.

If your insurance is not contracted with us, you agree to pay any portion of the charge not covered by insurance, including but not limited to those charges above the usual and customary allowance. If we are out of network for your insurance company and your insurance pays you directly, you are responsible for payment and agree to forwards the payment to us immediately. Our office policy requires payment from your carrier within 45 days. If we do not receive payment from your insurance carrier, the balance will be transferred to your responsibility. The only exception to the above policy applies to those patients who are covered by insurance companies that we are contracted with.

Patient Statement/Past due accounts

You will receive a patient statement from our office informing you of the balance that is due after your insurance has processed their portion. Payment is required within 30 days.

There is an additional service fee of $ 2.00 for each monthly statement mailed after the initial statement. If we do not receive any payments after 90 days from the date of service, or insurance processing date, we reserve the right to refer your account to an outside collection agency where you will be responsible for all collection and legal fees. We also reserve the right to terminate the patient and physician's relationship due to non-compliance with office policy.

Missed Appointments

If you need to cancel an appointment, we ask for at least a 24-hour notice. This allows us to offer the appointment to another patient. If you fail to keep appointments without letting us know in advance there may be a $ 50.00 charge.
We reserve the right to terminate the patient and physician's relationship due to frequent no shows and cancellations.

Prescription Refills

A $ 25.00 fee may apply for any after hour phone services rendered or prescription phone services.

Clerical Paper Work

Additional fees apply for clerical work such as sick leave, disability papers, etc.

AUTHORIZATION TO RELEASE INFORMATION: I understand that The Physicians Center for WellBeing will maintain records of my contacts for services and in general no information will be released without my specific written consent. I am aware, however, that information concerning my treatment and services rendered may be released as necessary to receive reimbursement by public and private health insurance plans. I authorize The Physicians Center for WellBeing to release any medical/psychiatric/substance dependency information necessary for the processing of claims. I permit a copy of this authorization to be used in place of the original. I request that payment under my medical insurance be made directly to The Physcians Center for WellBeing. I understand I am responsible for charges not paid by my insurance carrier.

I HAVE READ THE FINANCIAL POLICY (ABOVE). I UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY.

_____ _____ Date: