

## **FINANCIAL POLICY**

Thank you for choosing us as your healthcare provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy, which we require you to read and sign prior to any treatment.

### **Fees:**

Our fees are determined by the complexity of each case and different services used.

### **Regarding insurance:**

We will verify coverage prior to treatment and we will file all claims as a courtesy to you. If for any reason we are not able to verify coverage prior to your treatment, you will be charged for the treatment until verification is obtained. We cannot bill your insurance unless you bring us all necessary insurance information. We are not a party to that contract. By signing this document, you are assigning to this office the benefits to which you are eligible to receive for care rendered in this office. Additionally, in signing this document you authorize the release of any information to any insurance company, adjuster or attorney that will assist in the payment of a claim. We request a credit card on file if the insurance company should not pay claims or any balances owed should there be any difference in the amount owed.

### **Usual and Customary Rates UCR:**

Our practice is committed to providing the best treatment possible for our patients. We charge what is usual and customary for our area. Please be aware that some and at times perhaps all of the services may be non-covered services and not considered

reasonable and necessary by medical insurance. All payments are due at the time of service.

**Missed Appointments:**

Unless cancelled at least 24 hours in advance, our policy is to charge for missed appointment at the rate of a normal office visit if you are a repeat offender of this rule. Your treatments will be more effective if you follow your physician's guidelines and stick to your treatment schedule. Please help us to serve you better by keeping your scheduled appointments. Please let us know if you have any questions or concerns. I have read the financial policy and I agree to this financial policy.

---

PATIENT'S SIGNATURE

---

DATE

# FINANCIAL POLICY

## OFFICE FINANCIAL POLICY AND AUTHORIZATION TO BILL INSURANCE

There are two billing options available for you. Please select the one you prefer us to use for your visits. If at any time if you choose to change your billing option, you are required to let us know immediately and sign a new Office Financial Policy and Authorization to Bill Insurance Form.

\_\_\_\_\_ **Private Pay**

Private Pay patients are patients that do not bill insurance. **This discounted cash rate is only applied to the published rate if you pay at the time of service.**

\_\_\_\_\_ **Insurance Billing** (Medical or Auto Insurance)

I understand that I must pay all co-payments and/or co-insurances not covered by my insurance company at the time of check in for today’s visit, and every visit hereafter. INTEGRATIVE PAIN RELIEF will submit my claim for me to my insurance company. Although INTEGRATIVE PAIN RELIEF verifies my insurance; **I understand that this verification is not a guarantee of payment.** I understand that any and all charges incurred at this office including co-payment, co- insurance, percentage due and/or deductibles or any other fees or services not covered by my insurance company are **my responsibility. I understand that if these patient portions due are not paid at the time of service I will be subject to a \$10.00 billing fee per month – no exceptions until the outstanding amounts are paid.** I further understand that any unpaid balance **over 90 days**, can and will be sent to collections for recovery unless prior arrangements have been made.

I authorize my insurance benefits to be paid directly to INTEGRATIVE PAIN RELIEF. I also authorize the provider to release any information and medical records required by my insurance company. I understand that I may revoke this consent by written request, at any time. No other records shall be released without my signed consent.

Signature of Responsible Party

Date

\_\_\_\_\_

\_\_\_\_\_

Signature of Person Authorized to Consent

Date

\_\_\_\_\_

\_\_\_\_\_