BALANCE
INTEGRATIVE HEALTH

FINANCIAL POLICY FOR PATIENT CARE SERVICES

Balance Integrative Health wants to provide the most efficient and affordable health care services, so it is necessary for us to have a financial policy stating our requirements for timely payment of services and products provided by our office. We welcome the opportunity to discuss any aspect of our financial policy. To help us help you, please:

1) Provide us with accurate and updated information on yourself and your insurance company.
2) Pay at the time of service for your entire balance.
3) Discuss your account balance only with the Clinic Administrator. It is important for practitioners to be allowed to provide patient care.

Payment Practices

Balance Integrative Health gladly accepts health insurance, cash or debit/credit cards as forms of payment. We do not accept checks. Insurance coverage will be verified prior to or at the time of your visit. If we are not able to verify insurance coverage, full payment will be required at time of service or the appointment must be rescheduled.

Insurance Patients

We are happy to file for insurance as a courtesy to you. As stated by your insurance company: **"Verification of benefits is no guarantee of payment."** If you have insurance and we file with your carrier for you, you will be responsible for all charges not paid by the insurance company. In addition, the balance due is your responsibility if we have not received payment from your insurance company within 60 days.

Balance Integrative Health sends claims with procedure codes to the insurance companies. Your insurance company then chooses the "reasonable and customary" amount to apply to your visit. Your insurance plan is a contract between you and your insurance company, therefore any amount applied toward your deductible must be paid in full.

By signing this financial policy:

1) You are authorizing Balance Integrative Health, its providers, and its employees to release any necessary information related to this visit and all future visits to your insurance company for the purposes of claim(s) payment.
2) You are authorizing your insurance company and your medical provider to release your medical records to Balance Integrative Health for the purpose of your claim(s) payment.
3) You are authorizing your insurance company to pay all future claims for services provided by our office directly to Balance Integrative Health.
4) You are giving Balance Integrative Health the right to speak with your insurance company, any third party insurance company, and your attorney regarding your claims and bills.
5) You agree that a photocopy of any document is as valid and effective as the original.

Self-Pay Patients

If you do not have insurance or our services are not covered by your insurance company, you will be considered a "Self-Pay" patient and payment must be paid in full at the time services are rendered.

Cancellation Notice

Please be considerate of your appointment time and call if you cannot make your appointment or you are running late. We will make every atempt to accommodate you should you be late for your appointment, however if you are more than 15 minutes late for your appointment you will be charged for a missed appointment. Failure to cancel your appointment 24 hours in advance will result in a charge for your missed appointment.

Finance Charges

Failure to pay for services and products provided by our office will result in a finance charge. If we need to forward your account to a collection agency for further legal action, you will be responsible for the entire balance on your account plus any collection fees.

Payment Agreement

I authorize Balance Integrative Health to release any information required to process this claim to any insurance company or attorney in this case. This information is to be used for the purpose of processing my claims for benefits due. I hereby agree that a photocopy of the document is as valid and effective as the original.

I hereby authorize my insurance benefits to be paid directly to Balance Integrative Health. I assume full responsibility for and agree to pay all costs, charges and expenses of every kind and description for services furnished by Balance Integrative Health. I agree to pay for charges and services not covered by insurance or other third-party payer and/or not paid to Balance Integrative Health for any reason within a reasonable time (as determined by Balance Integrative Health). The amount of the bill shall be due and payable upon presentation to the patient, his/her agent, guardian, conservator, or third party responsible for payment of the charges.

Patient's Name (please print) _____

_____ _____

Signature of patient or legal guardian **Date**