Financial Policy

The Wellness Source, LLC

Thank you for choosing **The Wellness Source, LLC , doing business as "Your Wellness Sources" (YWS)** as your healthcare provider. We realize that the cost of healthcare is a concern for our patients and we are available to discuss our professional fees with you at any time. Your clear understanding of our financial policy is important to our relationship. The following is a statement of our Financial Policy, which you must read, agree to, and sign prior to treatment. Carefully review the following information and please ask if you have any questions about our fees, policies, or your responsibilities.

Provide Accurate Information: You have a responsibility to provide accurate and complete information about your health history, mailing address, health insurance and other billing information. If any information changes-name, address, phone, insurance coverage, etc. - you must inform this practice immediately. Insurance denials or billing errors due to patient supplied information will result in the immediate transfer of the account balance to the patient's immediate financial responsibility.

Know Your Insurance Coverage and Benefits: Your health insurance coverage is a contract between you and your health insurance carrier. **Patients are responsible for understanding their health insurance coverage(s) and benefits.** There may be limitations and exclusions to coverage. **You are responsible for any charges not covered by your plan.**

Insurance Accounts: We ask that you present your insurance card at **every visit.** If you fail to provide us with the correct insurance information at each visit a waiver must be signed and you may be responsible for payment for all services provided.

- Co-payments are due at the time of service, as it is a requirement placed on you by your insurance carrier. Please help us by paying your co-payment at each visit.
- If your insurance company requires you to pick a Primary Care Physician (PCP) one of our physicians must be the PCP listed on your insurance card.
- We will file claims to the insurance companies we contract with, provided that you authorize the "assignment of benefits" for payment directly to our practice. For plans that we participate in, the practice will accept payment based on contractual agreements. You agree to pay any portion of charges not covered by insurance.
- For insurance plans we do not contract with, we will file claims as a courtesy, provided that you authorize the "assignment of benefits" for payment directly to our practice. If your insurance does not pay within 60 days, you will be responsible to pay the balance of unpaid charges and follow-up with your insurance directly.

Self-pay Accounts: Self-pay accounts are patients without insurance coverage or who are unable to provide us with valid insurance information. If a patient is able to provide valid insurance information **within 30 days of the original date of service a claim will be filed with the insurance carrier.** If the insurance carrier issues payment for services rendered the patient will be issued a refund based upon the insurance payment**. Self-pay patients are responsible for paying 100% of charges at the time services are rendered.**

Worker's Compensation and Motor Vehicle Accident: In the case of a worker's compensation injury, motor vehicle accident and/or other third party liability you must obtain the claim number, phone number, contact person, and name and address of the insurance carrier **PRIOR** to your visit. Failure

to provide worker's compensation, motor vehicle accident and/or other third party liability information **within 30 days of the date of service may result in any unpaid balances transferring to patient responsibility. Payment for any services that we provide will ultimately be your responsibility if not paid promptly by another party**.

Statements: A statement will be sent to you once a balance becomes patient responsibility and will continue every 30 days thereafter. Unless you notify our office within 30 days of receiving your statement that you dispute the validity of the balance or any portion thereof, we will assume the balance is correct and valid.

Collection of Outstanding Balances: All outstanding balances shall be due within 14 days unless prior monthly payment arrangements have been made in writing. Balances that remain outstanding after 90 days or more may be referred to an outside collection agency/attorney and may result in termination of medical care by YWS. If your account is referred to an outside collection agency/attorney you may be responsible for paying any incurred collection agency/attorney's fees.

Types of Payments: Our practice accepts Debit, Visa, MasterCard, American Express, and Discover. Cash, check or money orders are also acceptable methods of payment**. If your check is dishonored (returned for non-sufficient funds) you will be required to pay an additional fee of $35.00.**

Missed Appointments: It is important that you appear for all scheduled appointments. By way of courtesy, we usually (but need not) call to confirm your appointment a day or two before the scheduled visit. If speaking to you is not possible for any reason, we attempt to leave a reminder message on an answering machine or voice mail**. Your failure to appear for a scheduled appointment or to cancel an appointment at least 24 hours prior to the visit may result in a missed appointment fee of $25.00.** This policy is aimed at minimizing waiting time and ensuring availability of medical care for all of our patients. We recognize the fact that there may be circumstances which may not permit you to give 24 hours prior notice but such occurrences are exceptionally rare and shall be considered on a case by case basis.

Miscellaneous Fees: Certain services (e.g. family conferences, completing forms, producing narrative reports, personal letters, etc.) may entail additional fees not covered by insurance and the office staff will inform you of those fees. Payment in full is expected at the time such services are rendered. Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of service. Our office will not bill any other personal party.

AUTHORIZATION I have read, understand and agree to the financial policy stated above and accept responsibility for payment of all fees/charges incurred with The Wellness Source, LLC, doing business as Your Wellness Sources.

_____ _____

Patient Printed Name Patient Date of Birth

_____ _____

Patient Responsible Party Signature Todays Date