Integrative Wellness Clinic
327 Medcrest Dr. Unit A. Crestview, Florida 32536
Phone 850-423-0761 Fax 855-793-3568

Financial Policy Authorization Form

Patient Information

- Name: _____
- Date of Birth: _____
- Address: _____
- Phone Number: _____
- Email: _____

PLEASE READ CAREFULLY

Our commitment is to provide the very best healthcare for you, our patient. Your clear understanding of agreement with our financial policy concerning your medical care is fundamental to our professional relationship with you. Should you have any additional questions about our fees and financial policies please contact our central billing office at 850-423-0761. If you have any questions concerning your individual benefits including your out-of-pocket responsibilities outlined in your plan. Please contact your carrier directly.

PROFESSIONAL FEES: Our prices are representative of the usual and customary charges for our area. Our fee reflects the providers' time dedicated and complexity to your care. That time includes the review of any prior medical records, diagnostic testing, authorizations, and other insurance requirements as well as the co-ordination of your care with other physicians involved in your health care planning.

INSURANCE PAYMENTS: We participate in assignment of payment with specific insurance plans in the State of Florida. Your insurance coverage is a contract between you and your insurance plan. It is your responsibility to verify and know your insurance benefits coverage including your out-of-pocket requirements. If your insurance is one with which we participate and if you have provided valid proof of insurance for that plan, we will submit your claim(s) as a courtesy to you, our patient.

PROOF OF INSURANCE: Before being seen by a provider, you must complete the patient information form; provide a driver's license or legal identification card; and provide a current valid insurance card as proof of insurance. If the insurance information you provide is incorrect, you will be responsible for the balance of the claim.

PATIENT PAYMENTS/SELF-PAY BALANCE: your co-payments, outstanding balance, services not covered by your insurance plan, and self-pay services are due at the time of your appointment. Your balances are due upon receipt of the Integrative Wellness Clinic unless you have made other arrangements prior to the service using rendered, you may pay by cash, check or credit card. We encourage you to use our secure Credit Card on File program for easy and convenient resolution of your balance. We accept Visa, Discover and American Express. After 90 days of non-payment, your account may be turned over to a collection agency.

APPOINTMENTS: Please understand that your appointment time has been reserved for your health care needs. If you are running late, please call us as soon as possible; if you need to cancel your office and/or procedure appointment, please call us 24 hours in advance. There is a $25 fee for no show.

SPLIT VISIT CARE: Some insurance plans allow for preventative care services (i.e., Annual Wellness Visit or physical) to be performed by the provider on the same day as a problem focused visit, while others require the services be performed on separate days. When preventative services are combined with a problem-focused visit, any applicable co-pays, co-insurance or deductibles may still apply as they relate to your problem-focused care. It is your responsibility to know your specific coverage requirements and any limitations that may apply.

NON-COVERED SERVICES: Some services you receive may be non-covered under your policy or may be considered not necessary by Medicare or other insurers. If your carrier determines this to be your responsibility you will be required to pay these charges.

MEDICARE BENEFICIARIES: Medicare will sometime limit coverage of certain goods or services based on the diagnosis or the frequency in which they are performed. In the event that your provider identifies the potential for denial of your claim for either of these reasons, in accordance with Medicare requirements, you will be asked to complete an Advance Beneficiary Notification Form (ABN) which will provide you the opportunity to be given the expected cost to you for the services - prior to service being rendered. You will be able to elect to receive the services and be responsible for the cost Medicare assigns or elect to decline the services.

COLLECTION AGENCIES: If it becomes necessary to place your account with a third-party collection agency due to non-payment, you may be considered for discharge from our practice. In the event you are discharged from our practice, we will treat you on an emergency basis only for the next 30 days while you find alternative medical care. Integrative Wellness Clinic and its affiliates reserve the right to request an active credit card to be placed on file for future services to be rendered and prompt resolution of future balances.

BOUNCED CHECK: A $50 charge will be applied for each check returned by your bank. If you have had more than one bounced check, your provider may elect to not accept future checks from you.

YOUR SIGNATURE ON THIS PAGE CONSTITUTES AN AGREEMENT TO THE FINANCIAL POLICY

I have read and agree with the above Financial Policy and Information. I hereby assign all medical and/or surgical benefits to which I am entitled through my insurance - governmental or private - to Integrative Wellness Clinic. This assignment will remain in effect until revoked by me in writing. A copy of this assignment is considered as valid as the original.

Signature of Financially Responsible Person

Patient Signature: _____

Date: _____

This form is compliant with the HIPAA privacy rule and includes the necessary elements to obtain patient consent for the release of health information, including sensitive data.