

## Integrated Health Concepts Financial Policy

Thank you for choosing Integrated Health Concepts as your health care provider. Although we commit to work diligently to ensure the best for you and your health, it is important to recognize that, ultimately, the responsibility for your health care rests with you. The following is a statement of our financial policy, which we require you to read, initial and sign prior to treatment. All patients must complete our information and insurance forms before seeing the provider.

- **PAYMENT IS DUE AT TIME OF SERVICE**
- **WE ACCEPT MEDICARE AND COMMERCIAL INSURANCE.** Please check with your insurance to verify that we accept your particular coverage. It is always the patient's responsibility to know if our office is participating with their plan. We also accept personal checks, cash, all major credit cards or money orders for payment of balances due by you

### **Regarding Insurance**

We may accept assignment of insurance benefits after your first visit. However, we do require either co-pay or co-insurance percentage of the bill to be paid at the time of service. The balance is YOUR responsibility whether your insurance pays or not. We cannot bill your insurance company unless you give us the correct insurance information. Your insurance policy is a contract between you and your insurance company. We are not party to that contract. If your insurance company has not paid your account in full within 60 days, the balance will automatically be transferred to your account as due from you. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/or other medical insurance. In the event that your insurance coverage changes to a plan that we are not participating with we do offer a discount. *Initial* \_\_\_\_\_

### **Regarding Medicare**

Medicare UGS only covers 80 percent of the billable charge. Therefore, leaving 20 percent the patient's responsibility which is **DUE** at the time services are rendered unless prior arrangements have been made. *Initial* \_\_\_\_\_

### **Regarding Self Pay Patients**

Self-pay accounts are patients without insurance coverage, patients covered by insurance plans in which the office does not participate, or patients without an insurance card on file with us. **A discount of 20 percent is given at check out.** As always, payment is DUE at the time of service. . Extended payment arrangements are available if needed. Please ask to speak with a billing coordinator to discuss a mutually agreeable payment plan. It is never our intention to cause hardship to our patients, only to provide them with the best care possible and the least amount of stress. *Initial* \_\_\_\_\_

### **Regarding Non-Sufficient Fund Checks**

The charge for a returned check is \$30 payable by cash or money order. This will be applied to your account in addition to the insufficient funds amount. You will be placed on a cash/credit only basis following any returned check. **Please note, the check will need to be paid before the next visit.** *Initial* \_\_\_\_\_

I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

X \_\_\_\_\_ Date: \_\_\_\_\_  
Signature of patient/ responsible party

*This financial policy helps the office provide quality care to our valued patients. If you have any questions or need clarification of any of the above policies, please feel free to contact us. And as always, thank you for allowing us to Participate in your care.*

