

## FINANCIAL POLICY

Thank you for choosing The Wellness Place, P.C. The following is a statement of our financial policy. All patients must accept our financial policy before receiving treatment. Please understand that full payment of your bill is considered a part of your medical treatment.

### **FULL PAYMENT IS DUE AT THE TIME OF SERVICE.**

FOR YOUR CONVENIENCE, WE ACCEPT VISA, MASTERCARD, CASH, AND LOCAL CHECKS.

**MEDICAL INSURANCE.** As a courtesy to you, we will submit your claim to your medical insurance company and we will accept assignment of benefits. Insurance COPAYS are due prior to receiving services. Your insurance policy is a contract between you and your insurance company and your account balance is your responsibility whether your insurance company pays or not. The Wellness Place, P.C. is not a party to that contract. You are responsible for verifying if The Wellness Place P.C. providers are in network with your insurance company. It is your responsibility to verify benefits covered by your plan as your insurance company may not cover all of the services provided to you. We will bill your insurance company ONLY if you present at the time of service your complete insurance information for commercial insurance, Medicare, or Nebraska Medicaid. If your insurance information is not received prior to treatment, payment is due in full at the time of service. If your insurance company has not responded and paid its portion of your account in full within 45 days of your date of service, the balance will be transferred to your account and it is your responsibility to pay in full by the statement due date. **A LATE PAYMENT FEE of \$10.00 will be applied to your account if full payment is not received by the statement due date. If a past due balance remains on your account after your third patient statement, no additional services will be provided until all past due balances have been paid in full.**

**MISSED APPOINTMENTS.** Please notify our office at least four hours in advance if you cannot make your appointment. **We reserve the right to discharge you from our practice if you accumulate THREE NO-SHOWS for scheduled appointments.**

**MINOR PATIENTS.** Minor children (age 18 and under) must be accompanied by a parent or legal representative. Registration, financial, privacy, health history, and insurance information must be filled out by a parent or guardian prior to any treatment. The parent or legal representative is responsible for full payment. Non-emergency treatment will be denied for unaccompanied minors (age 18 and under) unless permission to treat is written permission to treat is provided and registration paperwork is filled out prior to the visit.

**PERSONAL INJURY.** We will bill your primary medical insurance for personal injury claims. Or you may pay in full with cash, check, Visa, or MasterCard. We will not submit medical claims to automobile or third party insurance companies. We are not a party to any litigation suits filed for personal injuries. In all cases we require payment in full and any payment from litigation is to be sought by you for reimbursement for your medical services.

**WORK RELATED INJURIES.** We will not accept new patients for Workers Compensation (work-related) injuries. Established patients seeking treatment for work-related injuries MUST provide the following information prior to scheduling any appointments: Name and phone number of company, date of injury, name and phone number of supervisor or human resources manager, claim number, and name and phone number of Workers Compensation insurance company.

We will file your claim with your personal medical insurance. You will be required to pay any copay or coinsurance that your plan may require. For established work-related claims where you have already seen a Wellness Place provider, we will file Workers Compensation claims with your employer or your employer's Workers Compensation insurance carrier. If your company's workers compensation carrier has not paid your account in full within 45 days of your date of service, the balance will be transferred to your account and it is your responsibility to pay in full by the statement due date. We are not a party to any litigation suits being filed for work-related injuries.

**RETURNED CHECKS.** A **\$30.00 SERVICE FEE** will be added to all checks returned for insufficient funds. If your check is returned, you will be required to pre-pay in full by cash, Visa, or MasterCard for additional services.

**COLLECTIONS.** We reserve the right to forward your account to a collection agency to recover any unpaid balances.

**I HAVE READ, UNDERSTAND, AND AGREE TO THIS FINANCIAL POLICY.**

\_\_\_\_\_  
SIGNATURE of Patient or Patient's Legal Representative

\_\_\_\_\_  
Date Signed

\_\_\_\_\_  
PRINT NAME of Patient

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Relationship of Legal Representative to Patient