

NORTH HILLS INTEGRATIVE MEDICINE ASSOCIATES FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to giving you the best care available. We hope the following will answer any questions you may have about our insurance and billing procedures and policies in relation to your appointment and procedures.

Insurance: Your insurance policy is a contract between you and your insurance company. We are not a part of that contract. We cannot guarantee to you that your insurance will pay all, or any part, of your claim. It is your responsibility to verify with your insurance company, prior to treatment, your policy, coverage, benefits, and any deductible and/or co-insurance responsibilities. If your insurance company denies payment of your claim, you should contract your insurance company directly. If your company denies, or only pays a portion of your claim, please understand that you are personally and fully responsible for your total outstanding account balance(s). We will allow your insurance company a period of sixty (60) days to pay your insurance claim. If they have not paid by the 61st day, you will be held entirely responsible for any balance due, and you will be billed accordingly. Dissatisfaction with your insurance company does not constitute reason to withhold payment of your account with North Hills Integrative Medicine Associates.

We do accept assignment of your benefits, however, please be aware that some or all of the services provided may be a non-covered service under your plan. You will be responsible for these non-covered charges. It is your responsibility to:

- Ensure that we actively participate with your insurance carrier/plan
- Know your benefit coverage
- Ensure that all pre-approval requirements are met to avoid denials or out-of-network benefits.

Please remember that we must receive your billing information at the time of each visit in order to meet claims submission guidelines set by your insurance plan. If either the practice or the plan fails to receive accurate information necessary to process your claim, you will be held responsible. We must have a copy of your current insurance card to file for you or your family member. If you do not have your insurance card, we will ask for payment in full at the time of visit.

Regarding insurance plans where we are a participating provider, all co-pays, deductibles and co-insurance are due at the time of treatment. In the event that your insurance coverage relates to a plan where we are not a participating provider, you will be 100% responsible for all charges incurred. In summary, your financial responsibility pertains to:

- Denied and Non-covered services
- Services deemed not medically necessary by your insurance company
- Co-payments, deductibles, co-insurance
- Pending claims due to lack of patient and/or guarantor information
- Non-insurance and/or out of network benefit
- Self pay patients must pay in full at time of service.

Please be advised that you may receive a separate bill for Lab services. This is dependent upon your insurance benefits.

Estimates: Please remember that any charges you were provided when you scheduled your procedure were ESTIMATES only. Due to medical evaluation required for your complaints, we have no way of stating exactly what the charges will be prior to a visit.

Collections: Any past due balances not paid may be turned over to a collection agency after 90 days.

We accept all credit cards, cash, money orders and checks. A service charge of \$25.00 will be applied to your account for all returned checks or any stopped payment on an issued check.

Refunds: It is our policy to not issue refunds unless your account has a credit balance and all claims have been paid.

Missed Appointments: Please provide us with a 24 hour notice of cancellation so that we may utilize our schedule to provide better patient care. If you don't offer at least 24 hours advance notice, we may charge you a \$75.00 missed appointment fee. This charge will not be billed to your insurance company.

Authorization: I agree to be responsible for any medical expenses incurred with NHIMA, therefore, I authorize my insurance company, attorney, or other parties to pay directly to NHIMA, and/or provide any information regarding payment of my bill. I have read, understood, and agreed to the financial policy stated above and I accept responsibility for any balance not covered by my insurance company.

X _____ Date: _____
Signature of Patient or Responsible Party