

Pleasant Hill Wellness Center - A Medical Corporation

Financial Policy

Insurance/ Cash Patients

If you are financially responsible for services provided and are expected to pay at the time of services, we will courtesy bill your insurance. However, you will need to provide completed billing information at the time of your visit. A copy of your charges will be supplied to you so that you may follow up with your insurance company personally.

HMO/PPO Patients

If you are a member of an HMO/PPO you are required by your health plan to pay a co-payment at the time of your visit. We cannot waive the co-payment amount as a contracted provider. Co-payments will be collected at the time of services. Failure to provide co-payment at the time of service could result in an added billing fee in addition to the co-payment amount. Non-covered services must be paid at the time of service.

Medicare

We are Participating Providers in Medicare, which means that we accept Medicare assignment as payment in full, once your deductibles and co-payments have been made. We will bill Medicare for you, as well as your supplemental insurance carriers. You must provide us with valid cards from Medicare and your other insurance. Without these documents we cannot bill your insurance and payment will be expected from you at the time of your visit. Deductibles will require payment at the time of service.

Cancellations

If you are scheduled to see the physician and are unable to keep your appointment, please contact our office as soon as possible so we may schedule your time for another patient. Cancellations made less than 24 hours notice may be subject to a charge consistent with the time allotted for the visit.

No Shows

Failure to show up for your appointment creates gaps in our schedule and results in our inability to provide medical care for other patients. An initial no show will result in our contacting you as a reminder and for rescheduling. However, subsequent no shows will result in a minimum \$25.00 charge and/ or dismissal from the practice.

If you are experiencing financial hardship, please speak with our office manager regarding a payment plan. We accept MasterCard and Visa. A \$20 charge will be applied on returned checks.

By signing below, I acknowledge I have read the above financial policy.

Signed: _____

Date: _____

Name(printed): _____