



Financial Policy

Thank you for choosing us as your healthcare provider. We are committed to providing you with quality health care. We are sure you understand that payment for his health care is your responsibility. This Policy outlines your financial responsibilities related to payment for professional services. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

Insurance. We participate in most insurance plans. We are not a contracted Medicare provider. We will bill your primary insurance and, if applicable, a secondary insurance. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

1. **Proof of insurance.** All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance as proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the charges. If you do not have your insurance card with you, payment in full for each visit is required until we can verify your coverage.
2. **Co-payments and deductibles.** All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
3. **Non-covered services.** Please be aware that some – and perhaps all – of the services you receive may not be covered or may not be considered reasonable or necessary by insurers. You must pay for these services in full at the time of visit.
4. **Claims submission.** We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly to them. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays your claim or not. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

5. **Claim Payment.** If your insurance company does not pay within a reasonable time period, but not later than 90 days, you will be billed. If we later receive payment from your insurer, we will refund any overpayment to you.
6. **Coverage changes.** If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

Non-Insurance/Self-Pay. If you are not covered by an insurance plan we do business with and/or are a self-pay patient, payment in full is expected at each visit. We offer a cash allowance rate to established patients whose accounts are paid in full at time of service. The cash allowance rate only applies to office visits and does not apply to supplements, blood draws, labs, injectables or procedures.

Lab. We may obtain and process a specimen here in our office and send it to our third-party laboratory for analysis. This service is a convenience to you as it can be done at your time of service without you having to go to another location. You will be required to sign a separate Lab Payment Policy prior to lab collection which outlines the payment terms for labs.

Supplements. Many supplements are available for purchase at Salem Naturopathic Clinic. Most supplements are not covered by insurance. Payment for supplements must be made in full. They are not eligible for the cash pay allowance.

Non-Sufficient Funds. If you present a check for payment to Salem Naturopathic Clinic and it is not honored by your bank, a \$25 Non-Sufficient Funds charge will be added to your account per occurrence.

Medical Record Copies. Salem Naturopathic Clinic charges \$25 per request to copy your medical records for you. (This fee does not apply to records requests from other providers). You must complete a Medical Records Request Form and pay the copying fee prior to our releasing records to you.

Missed Appointments. As a courtesy, we request that you provide us with 24 hours notice if you must cancel or reschedule an appointment. After the second consecutive missed appointment with no advanced notice, a \$50 missed appointment fee will be added to your account. Payment of the missed appointment fee must be made prior to being seen at your next visit. After the third missed appointment without advanced notice, you will be dismissed from the practice. Please help us to serve you better by keeping your regularly scheduled appointment or providing at least 24 hours notice in the event you must cancel or reschedule.

Nonpayment. If you are a self-pay patient and your account is over 90 days past due OR if you are billing insurance and your account is over 120 days past due, you will receive a letter stating that you have 30 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a

balance remains unpaid, we will refer your account to a collection agency and you and your immediate family members will be discharged from this practice. In addition, if your bill is dismissed by a court as part of your bankruptcy, you and your immediate family members will be discharged from this practice. If you are dismissed from this practice, you will be notified by regular that you have 30 days to find alternative medical care. During that 30-day period, our physician(s) will only be able to treat you on an emergency basis.

Thank you for understanding our Payment Policy. Please let us know if you have any questions.

I have read and understand the Payment Policy and agree to abide by its guidelines:

Patient name (printed)

Date

Patient Signature

Relationship to Patient