Integrated Wellness Center

PATIENT FINANCIAL RESPONSIBILITY

CASH Accounts

We designate accounts as CASH under the following circumstances: (1) patient is covered by an insurance plan that our providers do not participate in; (2) patient does not have a current, valid insurance on file; or, (3) patient does not have health insurance coverage.

Payment is Due at the Time of Service

- We accept cash, checks, and all major credit/debit cards, including Health Savings Account and Flexible Spending Account cards.
- All co-payments and non-covered services are due at the time of service unless you have made payment arrangements in advance of your appointment. If you arrive without your co-payment, we may ask you to reschedule.
- If your plan has a coinsurance percentage and you do not have a secondary policy, please be prepared to pay a **minimum of $10.00 for chiropractic appointments and a minimum of $20.00 for massage therapy appointments** on the date of service.
- Patient responsible balances are due when you check in for your appointment.

Proof of Insurance

Please bring your insurance card(s) with you to your first appointment.

It is your responsibility to understand your insurance plan and its requirements/limitations regarding coverage for services we provide. As a courtesy, we will verify benefits as they relate to services provided at IWC, but we do not guarantee that information as definitive payment guidelines. Only your insurance carrier can determine exact payment protocol based on your individual plan. **We make NO guarantee of any estimated coverage since the insurance policy is an agreement between you and your insurance company.**

- It is your responsibility to notify the practice of changes in your health insurance. If we are not informed prior to your appointment and services are not covered, patient is responsible for payment in full.
- Should your insurance company reimburse you directly for claims we have submitted, we expect payment from you –IN FULL –within 10 days of the receipt of payment. The patient is ultimately responsible for payment for any charges incurred.
- It is your responsibility to inform the reception staff when the cause of treatment may be the responsibility of a third party or subject to liability insurance compensation (ie personal injury) - instead of your regular health insurance carrier. You are responsible to provide the office with ALL INFORMATION required to bill the third party when you check in for your appointment. Please note, we do **not** accept Worker's Compensation cases.

Referrals and Pre-Authorizations for Massage

- If your insurance plan has a designated primary care physician (PCP) and you are required to obtain a written referral from that doctor, you must provide the office with that referral at the time of check-in. If you do not have a current, valid referral, we may ask you to either reschedule your appointment or pay for the visit at the time of service.
- Many insurance plans now require medically necessary authorization for massage therapy services. This authorization is reviewed by a third party company, EviCore, after receiving care, and is either approved or denied for medical necessity. If a massage is approved, the amount you pay will be dependent on your

insurance plan. If a massage is denied, you will be responsible for the cash price of that massage. By receiving massage therapy care, you agree to these terms regardless of the final decision from EviCore.

IWC's Obligations

- It is our obligation under many of the insurance contracts to report patients who: repeatedly refuse to pay co-payments at the time of service; or, who repeatedly "no show" for appointments. We reserve the right to bill the patient for no shows or cancellation with less than 24-hour notice at the full cash price for the appointment.
- As a courtesy to our patients, we submit claims to your insurance carrier at no charge if you provide all insurance information and we are in contract with the carrier. We will stay in contact with your insurance company in an attempt to have the claim processed in less than 90 days, and will always follow-through on claims until a final decision is made by your insurance.

Divorce and Child Custody Cases

- In cases of divorce, the individual who receives care is responsible for payment of co-payments, coinsurance, deductibles, and nonparticipating insurance balances at the time of service. We will not bill a divorced spouse for the patient's services.
- The parent who brings the child to the office for care is responsible for payment at the time of service no matter if the account is Cash, participating insurance, or nonparticipating insurance. The practice does not honor divorce specifics (e.g., percentage of financial responsibility).
- If the child has coverage with a participating insurance plan and the proper insurance identification is present at the time of service, the practice will bill that insurance company. Applicable co-payments, coinsurance and/or deductibles are due at the time of service, unless arrangements have been made with the office prior to arrival.

Billing, Payments, and Refunds

- All balances are due in full within 14 days of the statement date.
- If you cannot pay the balance in full within 14 days, please contact our Billing Manager (206.780.8290 or billing@integratedwellnessbi.com) to see if you qualify for special payment options.
- It is your responsibility to notify the office of any change in address, phone, employment, or insurance coverage.
- If you make an overpayment on your account, we will apply that credit to your future treatments.
- We reserve the right to charge all accounts with a balance over 30 days from billing date a service charge of 1.5% per month.

We reserve the right to put your account in a collection program, report delinquent accounts to credit bureaus, assess a monthly collection fee of 10% of the balance due, take other collection action, and/or terminate you as a patient of this practice. In addition, if legal action is taken you will be responsible for the cost which may be up to $250.00 per hour.

I have read the Patient Financial Policy and I agree to abide its terms.

_____ _____

Patient Name (Please Print) Date of Birth

_____ _____

Signature, Patient or Legal Guardian Today's Date