BEYOND WELLNESS

Financial and Practice Policies

It is the policy of Beyond Wellness to collect any money due for all applicable deductible, co-insurance, co-pay's and/or self payments on the date services are rendered as indicated as due and payable by the patient's insurance company (if applicable). A receipt will be given for all collection of moneys received in the facility. **It is also the policy of Beyond Wellness to assure that all fiscal obligations are satisfactory for the patient and that every effort is made to assure the patient receives the scheduled care.** Please provide your insurance information to the front desk or the billing department and we will verify your coverage as a courtesy. **Although we are contracted with most insurance carriers, we also accept, and bill plans that we are NOT contracted with**. Being referred to our clinic by a provider does not necessarily guarantee that your insurance will cover our services, that we are a contracted provider with your plan or that we accept the same plans and carriers that your referring physician does. Please remember that you are 100% responsible for all charges incurred: your physicians' referrals, prescriptions and our verification of your insurance benefits are not a guarantee of payment. **Therefore, Beyond Wellness does NOT play any role in how your policy is written by your insurance company.** Do not assume that you will not owe anything if you have more than one insurance policy. If you need special arrangements to be made, please discuss this with the billing manager before starting your treatment.

Please initial your payment method and sign below that you have read, understood and agree with all of the information on this page:

_____**Private Health Insurance (PPO)**: All insurance plans require a referral or prescription with a diagnosis from your physician. Most insurance plans have patient responsibility of a deductible and either a co pay or co-insurance. **Deductibles and co pays are due at the time of services.** We will bill you for co-insurance or other payment due after we have been paid by your insurance or notified of their denial of payment. We can bill your insurance as a courtesy to you.

_____**HMO Insurance**: Authorization from your insurance must be obtained prior to treatment. **Any co pay or co-insurance is due at the time of treatment.** If your HMO plan has a Point of Service (POS) option you are using, please be sure you understand the difference in your POS coverage verses your HMO coverage.

_____**MEDICARE**: Beyond Wellness is a contracted Medicare provider. Medicare has an annual deductible of $240 for Part B **AND** a Co-insurance amount of 20% of the Current Year Medicare rate per visit **If you are currently a patient in a Skilled Nursing Facility or a Home Health Program, Medicare will NOT allow you to see Part B provider until you have been discharged from the program AND the information has been updated with Medicare directly.** Medi gap insurance covers the patients' portion due until your Medicare benefits are exhausted. Some insurance plans that are secondary to Medicare cover the patient portion due and services after Medicare benefits are exhausted, but not always.

__**WORKER'S COMP/PERSONAL INJURY**: **Authorizations from your insurance adjustor is required BEFORE you can begin treatment.** Please provide the billing dept with the name, phone number of your adjustor, the date of your injury, your claim or case number and any other pertinent information.

_____**SELF PAY**: I understand that I will be paying out of pocket and no charges will be submitted to insurance.

_____**Collections**: I understand and agree that I will be RESPONSIBLE for a Collections Fee of 40% of my balance owed if I am sent to a 3rd party collections agency.

Assignment of Benefits/Release of Information/Consent to Treatment

I have read and I agree with the above policies. I hereby authorize/assign my therapy insurance benefits to be paid directly to Beyond Wellness. I also authorize Beyond Wellness to release any necessary information to process my claims. I authorize the release of any medical information necessary to process claims. By signing below, I authenticate that authorization for Assignment of Benefits and Consent to Treatment by Providers at Beyond Wellness. I also understand that I am responsible for all collection and attorney fees incurred to collect my past due accounts

Print Patient Name: _____

Print Parent/Guardian Name (if patient is minor):_____

Signature of Guarantor / Account Responsible: _____Date: _____