



## **Financial Policy**

Thank you for choosing Advanced Wellness Center for your health care needs. The following is a statement which explains our financial policy. This policy must be read and signed prior to treatment. If you have any questions regarding this policy please discuss these matters with us immediately. We will be happy to explain any statements which appear unclear or confusing, as to avoid any misunderstandings.

### **PAYMENT AT THE TIME OF SERVICE**

Payments may be made by cash, check or credit card. By paying at the time of service, you will receive a discount, which is only valid when payment is **received on the day of service**. If any billing is to occur, which should be arranged before the time of service, you will be billed at the regular office rates.

### **USUAL AND CUSTOMARY RATES**

The rates established for this clinic fall within the usual and customary rates for this area. We are dedicated to provide our patients with the best treatments possible for these rates. Regardless of your insurance company's agreement with these rates, you are responsible for payment in full.

### **INSURANCE**

As a courtesy to you, we will bill pre-authorized insurance companies for you. All co-payments, deductibles, and payments for services which are not covered under your insurance policy are due at the time of service unless prior arrangements have been made. Payments can be made by cash or check. Any balances which remain unpaid for 60 days or longer will be charged interest of 2.5% per month. If you are unable to pay in full at the time of service, it is your responsibility to contact our office to arrange a payment plan. Your insurance policy is a contract between you and your insurance company. Advanced Wellness Center is not included in this contract.

### **ACCIDENTS/INJURIES**

This clinic will make every effort to recover our fees from all available sources, including health insurance, auto insurance, etc. However, any unpaid balances are ultimately your responsibility, and you will be required to pay this balance in full.

### **MINORS**

Minors will be accompanied by a parent/legal guardian for the first visit. Payment is the responsibility of the parent/legal guardian.

### **MISSED APPOINTMENTS**

24 hours notice is required for cancellation of appointments with this office. This office reserves the right to charge \$25.00 for any appointments that are not cancelled within this time frame.

### **PATIENT'S AGREEMENT**

I have completely read and understand the Financial Policy of Advanced Wellness Center. I understand and agree that I am responsible for payment for services and products provided by this clinic. I am also responsible for payment of any fees that may accumulate while trying to collect my unpaid balance; this may include but is not limited to attorney fees.

Signature \_\_\_\_\_ Date \_\_\_\_\_

(Signature must be provided by parent/guardian if patient is less than 18 years of age)