SERENITY WELL-BEING CLINIC P.A. FINANCIAL POLICY

WELCOME TO OUR OFFICE - We are pleased to welcome you as a patient. We take pride in our ability to build a mutually beneficial relationship with our patients and are very committed to your treatment. We feel that it is crucial for you to have a clear understanding of our billing and payment policies. Please feel free to ask any questions.

CO-PAYS are due at the time of service or we reserve the right to reschedule your appointment to another time.
THERE WILL BE A $30.00 FEE ASSESSED TO ALL NSF CHECKS WITH NO EXCEPTIONS.

INSURANCE- Patients need to abide by the rules of their plan regarding referrals, co-pays, and pre-certifications. Medicare patients are required to meet their calendar year deductible. If your insurance company requires a referral from your primary physician, it is your responsibility to make sure our office has a copy. Please be advised that we bill only the primary and secondary insurance carriers. We do not bill a third insurance, however, we will make available a claim form for the patient to submit themselves. Patients who do not have medical insurance will be required to pay for the services rendered in full at the time of the visit. We will try to accommodate patients by supplying an estimate prior to seeing the Doctor.

SUPPLIES- Most supplies (i.e. post-op shoes, padding, pre-fabricated orthotics, heel cups, lotions etc.) are not covered by insurance and you are responsible for payment at the time of dispensing. There are no refunds on any medical equipment dispensed.

CANCELLATIONS- With respect for other patients seeking treatment, we ask that you notify our office at least 24 hours prior to cancellation or change of appointment. Reminder calls will be made the day before. There will be a $40.00 fee for missed appointments.

MINOR PATIENTS- The adult accompanying a minor is responsible for payment. No treatment will be rendered to unaccompanied minors.

ANY ACCOUNT BALANCE NOT PAID IN FULL WITHIN 60 DAYS WILL BE SUNJECT TO A MONTHLY FINANCE CHARGE OF 1.5% PER MONTH AND A MONTHLY COST OF REBILLING AND ACCOUNT MAINTENANCE CHARGE OF $5.00. IF ANY ACCOUNT BALANCE SHOULD REMAIN UNPAID FOR 90 DAYS IT WILL BE TURNED OVER TO THE COLLECTION AGENCY.

By signing below you are stating that you have read, understood and agree to the terms and conditions of this Financial Policy. Please let us know if you have any questions or concerns.

Signature of Patient or Responsible Party **Date**