

Financial Office Policy

All recommendations of Serenity Health and Wellness, are based on a desire to see you get well and stay well. We ask that you read and understand our Financial Office Policy as it applies to your patient financial responsibilities.

For all insurance policies : We will submit a claim one time on a patients behalf. You are responsible for payment of all services your insurance company may deny or fail to pay. We encourage patients to pay their estimated patient responsibility at the time of service. If you decide to wait for your insurance to pay their portion, a written invoice will be issued and you will have 30 days to make prior arrangements. After the 30 day mark, collection measures will be taken.

For non-insured patients: All payments are due at the time of service.

Please choose the following that apply:

- You are required to pay a \$ _____ copay per visit.
- You are required to pay toward your _____ deductible.
- You are required to pay _____ percentage of the total services for each visit.
- You are involved in a motor vehicle accident, workmans compensation case or personal injury and will assign all payments to Serenity Health and Wellness
- Your insurance has no benefits for care, or you are a self pay patient, and all service fees are due at the time of service.

As the recipient of services from Serenity Health and Wellness you are ultimately responsible for payment for all services provided. We require all patients to keep a credit card on file. Any outstanding payments or balances due, as a courtesy, will be sent in the form of a paper invoice to the current address on the account. If payment or payment arrangements have not been made within 30 days of receipt of invoice, you are authorizing Serenity Health and Wellness, to charge your card for any unpaid balances or bills due.

Additionally, Serenity Health and Wellness reserves the right to charge a missed visit fee of 75.00 for an existing missed patient visit, 100.00 for an hour appointment, or 150.00 for a new patient missed visit. One missed visit will be waived and additional visits will be charged to the card on file on the date of missed visit.

I, _____ on date ____/____/____

(please print your name or legal guardian name)

do understand my patient financial responsibility. A representative of Serenity Health and Wellness has explained my insurance benefits. I hereby authorize the doctor to release all medical information necessary to process my insurance claims. I authorize the use of this signature on all my insurance or employee health benefit submissions. I assign and convey directly an assignment of benefits, and release payment for services from my insurance company or responsible party to Serenity Health and Wellness. I have read this financial policy and do understand that I am financially responsible for all charges incurred.

X _____ Relationship to Patient : _____

(please sign your name)

Credit Card # : _____ Expiration Date : ____/____