STAT WELLNESS
PRIMARY HEALTHCARE

FINANCIAL POLICY AND DISCLOSURE
(PLEASE INITIAL SIGN AND DATE)

STAT Wellness Center, PLLC is committed to excellent patient care. The following guidelines will provide you with specific information regarding our financial policies. We believe that your understanding of these policies is important to our professional relationship.

Insurance: We participate in most insurance plans, including Medicare. If you are not insured by a plan we accept, payment in full is expected at each visit. If we do accept your plan, but you do not have a current insurance card, payment in full for each visit is required until coverage is verified.
Initial: _____

Copayments: All copayments must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure to collect copayments and deductibles from patients is against the law.
Initial: _____

Self-Pay: If you are a self-pay patient, you will be required to pay for the office visit before services are rendered. In addition, any remaining balance on your account will be collected at discharge.
Initial: _____

Payment: We accept payment by cash, check, credit/debit cards. All previous balances must be paid at time of service, unless prior arrangements have been made with the billing department. If a check is returned for insufficient funds or payment has been stopped, you will be charged a $35 fee in addition to the amount of the check. You will also be asked to pay by cash, credit or debit card for future visits.
Initial: _____

Claims submission: We will submit your claims and assist you in any way we reasonably can to help get your claims paid. To submit claims, we must have the patient's date of birth, social security number and a copy of photo identification. In addition, we must obtain the policyholder's date of birth and social security number to file claims with your insurance company. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility, even if your insurance company denies your claim. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract.
Initial: _____

Nonpayment /Overdue Balances: If your account becomes delinquent, you agree to pay any charges to collect your unpaid bills, including but not limited to, reasonable court costs, and/or collection agency fees. After you have received two statements, your account is considered past due. Payment plans are available but must be negotiated with the billing department prior to your account being sent to collections. You must contact us for a reasonable payment arrangement or risk collection action.
Initial: _____

Missed Appointments: If you do not show up for your appointment and you do not cancel the appointment 24 hours in advance, you will be assessed a NO-SHOW fee of $25.00. This fee will be your responsibility and must be paid prior to your next visit. This policy allows us to make better use of our available appointments for those patients in need of medical care. Repeated missed appointments and/or no-shows may result in discharge from the practice.
Initial: _____

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. If you have any questions, please feel free to discuss with the front desk staff or the billing department. Please do not discuss financial aspects with the provider.

Responsible Party Signature: _____ Date: _____