ACE HEALTH AND WELLNESS CENTER FINANCIAL AGREEMENT

PATIENT FINANCIAL AGREEMENT

Thank you for choosing us as your primary care provider. We are committed to providing you with quality and affordable healthcare. We ask all patients to review and sign this policy, asking questions as necessary. A copy will be provided upon request.

1. **Insurance:** We accept assignments and participate in most health insurance plans**. It is your responsibility to know your insurance benefits.** Please contact your insurer with any questions you may have regarding your coverage to receive the maximum benefit. But we are here to help and will try to provide assistance when requested.

   If your insurance is not a plan we participate in, or if you do not have insurance, payment in full is encouraged at each visit. We offer self-pay discount to uninsured patients when paying at the time of service.

2. **Copayment:** All copayments are to be paid at the time of service. This arrangement is part of your contract with your insurance company.

3. **Insurance Information:** All patients are responsible for providing accurate insurance information. If you fail to provide us with the correct insurance information, or your insurance changes and you fail to notify us in a timely manner, you may be responsible for the balance of a claim. Most insurance companies have timely filing restrictions; if a claim is not received within timely filing requirements, it can be rendered ineligible for payment, and you will be responsible for the balance that remains.

4. **Claims:** We will submit your health insurance claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may not accept information from our office and may need information from you. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether your insurance company pays or not. Your insurance benefit is a contract between you and the insurance company; we are not party to that contract.

5. **Fees:** Past due accounts will be subject to a $5.00 monthly late fee. Bounced checks will be charged a $25.00 fee.

ACE HEALTH AND WELLNESS CENTER FINANCIAL AGREEMENT

6. **Collections:** If your account is more than 90 days past due, you will receive a final statement informing you that you have 30 days to pay your account in full or establish a mutually agreeable payment plan. Please be aware that if a balance has remained unpaid, it may be sent to a collection agency. If an account is sent to collections, it is the policy of this office to suspend care for the patient and possibly immediate family members until financial arrangements have been made.

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read and understand the financial policy and agree to abide by its guidelines.

☐ **I accept the terms and conditions.**

_____

Patient Name

_____ _____

Patient Signature **Date**