**Financial Policy**

Client’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Infinity Wellness Center has established a financial policy to assist our patients in having a clear understanding of the financial responsibilities of both the practice and the patient. The intent of this document is to inform patients about the financial policies. All policies are created in an effort to minimize discrepancies not only for Infinity Wellness Center but more importantly for patients. Please feel free to ask any questions regarding this policy.

**Blue Cross Blue Shield (BCBS) Families:**

Infinity Wellness Center is in-network with Blue Cross Blue Shield PPO and Traditional Plans only. As an in-network provider, we will do our best to verify your benefits and let you know your copay and deductible amounts as well as any charges not covered by BCBS however the information we have is not always accurate. Please contact your insurance police, there should be a number on the back of your insurance card. It is your responsibility to understand what services are covered and what your deductible or out of cost you will be responsible for paying.

**Non Blue Cross Blue Shield (BCBS) Families:**

Families who do not have BCBS insurance will be expected to pay for services at the time of the appointment. If you would like to submit information for reimbursement to your insurance company, please let your therapist know and a form will be provided that includes the necessary information.

Reimbursement amounts for all insurance plans vary and are not guaranteed. Only services considered medically necessary and meet insurance plan guidelines can be submitted for reimbursement.

Patient responsibility:

* Payment of patient responsibilities is required at the time of service
* Our practice collects patient responsibilities such as co-pays, coinsurance, deductibles and outstanding balances prior to your appointment.

**Cancelation Fee:**

* There is a $100.00 no show or cancellation fee for all appointments with any of our providers. If you cancel less than 24 hours in advance you will be given one bypass. Any future late cancelations or no-shows will be charged $100 per occurrence.
* Should a patient no show or cancel an appointment without the required 24 hour notice, the fee will be charged to the credit card of file. It is your responsibility to let the therapist know if you have a different card to be used. If you want an alternative card used it must be provided prior to the day of late cancelation or no show.

**Collection Fee:**

* Outstanding balances greater than 60 days past due will be charged to the credit card on the file unless other arrangements are made. If there is an outstanding balance on the account that we are unable to collect or charge to the credit card on file we will add a $10 non-payment fee to the account each month until the balance is paid in full.
* If the account is sent to a collection agency, we agree to only share with them the information required to collect the balance due including fees.

**Credit Card Processing Fees:**

* Due to the increasing costs for processing credit card payments, we will add a 3% fee on all payments made using the credit cards. This fee is not greater than our costs of acceptance. To avoid this fee please use cash or check for payment.

I \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (parent/ guardian of above stated child) agree to pay any no show/ cancelation, late fees, collection fees or credit card fees that may fall under the policies listed above.

My signature below indicates that I understand and agree to the above financial policy.

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Parent/Guardian Signature Date