COASTAL INTEGRATIVE HEALTH

One Patient, Multiple Solutions

728 Village Rd. SW
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OUR FINANCIAL POLICY

Thank you for choosing our practice as your healthcare provider. Our office is dedicated to providing optimal care for every patient in the most economical way possible. The following is a statement of our financial policy. Please read it and let us know if you have any questions. We feel misunderstandings can be avoided when complete information is exchanged.

OPTIONS FOR PAYMENT OF TREATMENT:

1. Non-insurance Patients:
   Payment is expected at the time of service for treatment performed that day unless prior arrangements have been made. For your convenience, we accept cash, personal checks, money orders, Mastercard, Visa, Discover and Care Credit.
2. Insurance Patients:
   a. We will file an insurance claim on your behalf as a courtesy to you; however, you must supply, prior to treatment, all necessary information for filing.
   b. Any deductible, co-payments or estimated percentages your insurance does not cover are to be paid on the date of treatment.
   c. It is the patient's responsibility to know the details of the insurance coverage, including percentages payable, waiting periods, deductibles, yearly maximums, services not covered under the plan, and any other related information.
   d. If your insurance company has not paid their liability in full within 60 days, the balance then becomes the patient's responsibility.
   e. For those patients whose insurance company pays them directly, payment is expected on the date of treatment.
   f. Your insurance policy is a contract between you and your insurance company; and the financial responsiblilty for your treatment is yours whether the insurance company pays or not.
3. If you need to consider long term payments, a Financial Contract Agreement must be agreed upon and signed by both the patient and the authorized representative of this office on your first date of treatment.
4. Our office will submit monthly statements to you to keep you advised of your responsible portion of your balance. If a payment is not received by you for any balance due within 30 days of the statement date, collection proceedings will begin. The patient will then be responsible for any collection fees or attorney fees incurred.
5. Any checks returned for non-sufficient funds will be assessed a $20.00 charge, payable in cash immediately.

Again, please feel free to ask any questions you may have regarding this policy. We are most willing to help you in any way we can.

I HAVE READ THIS FINANCIAL POLICY AND UNDERSTAND AND AGREE TO THE TERMS OF THIS POLICY.

X_____ _____

Signature of Patient/Responsible Party Date