Rancho Wellness
YOUR MEDICAL HOME

RANCHO WELLNESS FINANCIAL POLICY

We would like to thank you for choosing Rancho Wellness as your primary care provider. We are committed to providing you quality and efficient health care with a smile. In an effort to provide you with the best possible experience during your office visit, we have developed this policy which details our financial requirements to help you understand your responsibilities as a patient.

Knowing your insurance benefits, including co-pays, co-insurances and yearly deductibles, is your responsibility and these are to be paid at time of visit. If you have a yearly deductible that has not been met, a credit card will be kept on file securely, and a deposit towards that visit will be collected at the time of visit. If there is a remainder balance for your visit, once we receive the explanation of benefits, the credit card on file will be charged automatically **ONLY AFTER** 45 days from the time a statement is sent to you and we have not received payment. If for some reason, your insurance pays 100% of the claim, you will have a credit on your account that can be used for future visits. **Initials** _____

All co-payments are due at time of visit. **NO EXCEPTIONS!** We do not except checks. If your insurance company does not pay your claim within 60 days, the balance will automatically be billed to you. **Initials** _____

The responsibility for payment of fees for services is the direct responsibility of the patient. Your health benefit plan is an arrangement between you, the enrollee and the insurance company, HMO or your employer. Your health benefit plan determines your coverage, requirements, and establishes the limit on your coverage for medical services based on what they determine as medically necessary. However, we will do our best to assist you with understanding your proposed treatment and in answering questions related to your insurance.

CANCELLATION/NO-SHOW POLICY:

We understand that there may be times when you miss an appointment due to emergencies. We **URGE** you to call **24 hours** prior to cancelling your appointment. Failure to do so may result in a charge of **$35.00.** If you "no show" for two consecutive appointments or cancel for a total of four appointments without notification, you **WILL** be discharged from care. **Initials** _____

CONSENT FOR TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION:

I, _____, certify that I (or my dependant) have insurance with _____. I assign directly to Rancho Wellness, all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for **ALL** charges whether or not paid by any insurance and/or any charges incurred during collection action. I herby authorize Rancho Wellness to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I acknowledge receipt of the Practice's Notice of Privacy Practices. I authorize the practice to use and disclose my health information for purposes of treating me, obtaining payment for services rendered to me and conducting healthcare operations.

Patient/Guarantor Signature _____ Date _____

Our practice is committed to providing the best possible care to our patients. Thank you for understanding our payment policy.

I have read and understand the payment policy and agree to abide by its guidelines: YES/NO

_____ _____

Signature of patient or responsible party Date

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