First Health Financial Policy (updated 10/15)

Non-Insured Patients If you do not have insurance, or if your services are rendered by one of our providers who do not accept insurance, all payments are expected at the time of service. First Health does not accept insurance assignment for Chinese Medicine, Nutrition & Weight Loss Programs, Massage or any supplies or supplements.

Health Savings Account Patients Most HSA Plans reimburse you, the patient, directly for many of the services that are not covered under typical health insurance plans. We do require payment at the time of service. We will provide you with a statement appropriate for re-imbursement. Please check your plan for coverage specifics.

Insured Patients If you are seeing a provider that accepts insurance, and agree to our credit card on file policy, we will extend you the courtesy of assigning your benefits directly to us and submit your claims for you. This courtesy reduces your direct out-of-pocket expense.

Please Read & Initial to indicate you agree to the following: (Any questions, see Front Desk)

_____ ***(Initial)*** Co-payments are due at the time of service. If you leave the office without paying a co-payment, your credit card on file will be charged automatically for the co-payment amount and a receipt sent to the address on file. For patients with Co-Insurance, payments can be paid weekly and applied to your account to keep your co-insurance expense down. Once your EOB and payment are received by your insurance, any balance left on your account will be charged immediately to the credit card on file and a receipt sent to the address on file. **First Health Associates Does Not Send Out Monthly Statements**. Any credit balances from prepaid co-insurance will be refunded immediately.

_____ ***(Initial)*** You are considered a cash patient until your portion of all necessary insurance forms has been completed by you and received by our front desk. We do not accept assignment for supplemental or secondary insurance plans. We will, however, provide you with the completed claim forms for your own submission.

_____***(Initial)*** Our fees are considered usual and customary by virtually all insurance carriers we accept at First Health. Should your carrier be one not in our network, we will not be responsible for re-imbursement deficits.

_____***(Initial)*** If your carrier has not paid any claim within **30** days of submission, you should consider contacting your insurance company to find out why. Most companies will expedite your claim if they hear directly from you. If for any reason your carrier has not paid for your service within **60** days from the date of submission, payment is due immediately, and, by signing this agreement, you understand and agree to payment terms.

_____***(Initial)*** To implement our Financial Policies, we do require that all patients post a valid credit card as assurance for any and all unpaid balances as described above.

_____***(Initial)*** **Cancellation Policy** 24 hour notice is required to cancel an appointment free of charge. Missed Appointment Fees for cancellations without 24 hr notice are $100.00 for medical and behavioral counseling services. Missed Appointment Fees for other providers and services will be the actual amount of an appointment for which you are scheduled.

_____***(Initial)*** **Email/Phone Consult Policy** Because of the potential conflict with HIPPA, FHA will no longer be responding via email on health matters. For your convenience, we have set up a new telephone consultation system. Please be advised that we do not bill insurance for telephone consults and payment is due at the time of scheduling. Scheduling and billing are done at 15 minutes increments. To schedule, please contact the front desk.

Date:_____ Patient Name:_____Signature:_____

First Health Associates, SC
Credit Card Pre-Authorization Form

I _____authorize FIRST HEALTH ASSOCIATES, SC to keep my signature on file and to charge the credit card listed below for all reasons stated in their Financial Policy listed on page one which I have read and agree to.

Signature _____

I Allow Charges for the following family members:

_____ _____
(authorized family member) (authorized family member)

_____ _____
(authorized family member) (authorized family member)

Patient's Name:_____

Cardholder Name:_____

Cardholder Address:_____

City:_____**State:**_____**Zip:**_____

Credit Card Number:_____ **Exp.Date:**_____

Cardholder Signature:_____**Date:**_____

- ***WE accept VISA, MASTERCARD, DISCOVER & AMERICAN EXPRESS***