KETAMINE HEALTH &
RESTORATION

**Financial Policy Agreement**

**Ketamine Health & Restoration** believes that part of good healthcare practice is to establish and communicate a financial policy to our patients. We are committed to providing the best possible care for you, and we want you to completely understand our financial policy.

**PAYMENTS**

We will accept only credit cards. Payment will include any unmet deductible, coinsurance, co-payment amount, or non-covered charges from your insurance company. If you are not enrolled in an insurance plan which covers services at our office, payment in full is expected at the time of your visit. We will ask for your ID card or license to make a copy for verification purposes only.

**INSURANCE**

We are participating providers with several insurance plans, and we file the necessary insurance claims. A list of insurance plans is available upon request. Please remember that insurance is a contract between the patient and the insurance company and ultimately the patient is responsible for payment in full.

If your insurance company does not pay the practice within a reasonable period, you will be billed. If we later receive payment from your insurer, we will refund any overpayment to you. If our practitioners are not listed in your plan's network, you may be responsible for partial or full payment.

If you are insured by a plan with which we have no prior arrangement, we will prepare and send the claim in for you on an unassigned basis. This means the insurer may send the payment directly to you and therefore, our charges for you are due at the time of service. Due to the many different insurance products out there, our staff cannot guarantee your eligibility and coverage.

Be sure to check with your insurer's member benefits department about services and providers before your appointment. Many websites have erroneous information and are not a guaranteed coverage. You are responsible for obtaining a properly dated referral if required by your insurer and responsible for payment if your claim rejects for the lack of one. Not all insurance plans cover all services.

If your insurance plan determines a service to be "not covered", you will be responsible for the complete charge. Payment is due upon receipt of a statement from our office. All procedures

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billed in this office are considered covered unless limited by your specific insurance policy. Patients who insist on a "day of" urgent/emergent scheduling or care after hours or on days the clinic is closed will be assessed additional urgent care or after-hours fee. These fees will be billed to your insurance carrier or collected as part of the office charges for self-pay patients.

**ACCOUNTING PRINCIPALS**

Payment and credits are applied to the oldest charges first, except for insurance payments which are applied to the corresponding dates of service.

**FORMS FEES**

Completing insurance forms and copying medical records and other documents requires office staff time and time away from patient care for our doctors. We require pre-payment for completing forms, copying medical records, notarizing, or for extra written communication by the doctor. The charge is determined by the complexity of the form, letter, or communication. Base form charges are $10 per occurrence plus applicable postage or notary fees. Postage is an additional charge and payment is required in advance. Copying fees for Medical Records are $10 for the first twenty (20) pages and $0.50 per page for more than twenty (20) pages. **Ketamine Health & Restoration** will have 15 business days in which to copy records before making them available for patient pick up, and these 15 days will commence after payment for copying has been received and after the patient has signed this form authorizing records' release.

**CANCELLATIONS OR MISSED APPOINTMENTS**

If you do not cancel your appointment at least 24 hours before, or if you no-show, we will assess you a $50 missed appointment fee.

**RESPONSIBILITY FOR PAYMENT**

I understand that I, personally, am financially responsible to **Ketamine Health & Restoration** for charges not covered by the assignment of insurance benefits.

**ASSIGNMENT OF INSURANCE BENEFITS**

I hereby assign, transfer, and set over directly to **Ketamine Health & Restoration** sufficient monies and/or benefits for basic and major medical to which I may be entitled to professional and medical care, to cover the costs of the care and treatment rendered to myself or my dependent in the said clinic. I authorize **Ketamine Health & Restoration** to contact my insurance company or health plan administrator and obtain all pertinent financial information

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concerning coverage and payments under my policy. I authorize **Ketamine Health & Restoration** to release all medical information (including, but not limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and HIV or communicable diseases) requested by my health insurance carrier, Medicare, Medicaid, other physicians or providers, and any other third-party payers.

**SELF-PAY PATIENTS**

Please ask about our self-pay rates. All services are expected to be paid in full at the time of service. Under extenuating circumstances, you may be eligible for payment arrangements on a case-by-case basis.

**Service Fee Schedule:**

- New Patient (Evaluation & Treatment) – **$300**
- Follow Up (Evaluation & Treatment) – **$150**

**RELEASE OF INFORMATION**

I hereby authorize and direct **Ketamine Health & Restoration** to release to governmental agencies, insurance carriers, or others who are financially liable for such professional and medical care, all information needed to substantiate claim and payment.

**COLLECTION FEES**

I understand that in the event my account is placed in collection status, any additional fees incurred due to this, will be added to my outstanding balance. This includes but is not limited to late fees, collections agency fees, court costs, interest, and fines. I understand that these additional fees will be my personal responsibility to pay in full. I have read and understand the practice's financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice as necessary.

Signature: _____

Print Name: _____

Date: _____