



2117 Bentley Plaza • Fenton, MO 63026 • Phone (636) 825-2200 • Fax (636) 825-2201

Office Policies

PAYMENT & INSURANCE RELEASE AGREEMENTS

- I (being the responsible party for the patient identified below) hereby agree to pay for all copayments/co-insuredeductibles at the time of each visit, and for Delta Health to bill for and receive direct payments from my insurance companies for services rendered by Delta Health. In the event that the insurance company refuses payment for services rendered at Delta Health, I acknowledge and agree that I will be held responsible for the payment in full.
- Payments for self-pay/cash patients are due at the time of the visit.
- I hereby authorize that payment of Medicaid, Medicare, Medigap, or other insurance company benefits, otherwise payable to me, be made to Delta Health, for this outpatient treatment or series of treatment. I authorize the release to the Centers for Medicare and Medicaid Services and its agents of any information needed to determine these benefits are payable.
- I authorize Delta Health to call my home/cell, either in person or through our automated system to provide patient appointment reminder calls on a regular basis.
- I agree to the following terms and conditions for collections of payments for services performed by Delta Health.
 - Delta Health will request a standard copayment of \$20.00 for the initial treatment sessions if the patient’s insurer does not verify to Delta Health the copayment amount at the time pre-authorization is given, and if the copayment amount is unknown to the patient. Delta Health will either credit the patient’s account or will make direct reimbursement to the patient of any over-payments identified, once accurate copayment information is verified for Delta Health by the patient’s insurer.
 - There will be no charge for a cancelled visit if the cancellation is made greater than 24 hours prior to the visit.
 - Delta Health reserves the right to charge a standard \$75.00 charge for a cancelled visit if the cancelled visit is made less than 24 hours prior to the visit time or if there is a No-Show for the appointment. Any resulting charge from late cancellation or non-attendance is due before the next visit and will not be submitted to a third party carrier. **I will be solely responsible for this charge.** When I pay by check, I expressly authorize Delta Health, if my check is dishonored or returned for any reason to charge me the amount of the check plus a processing fee of \$35.00 plus any applicable sales tax. The use of a check for payment is my acknowledgement and acceptance of this policy and its terms.
 - In the event that an overdue outstanding balance should be placed with an outside Collection Agency, I will be liable for any court cost, attorney fees, and collection cost.

Late Arrivals

The patient’s appointment is scheduled for a specific block of time, and will end **on time** even if you arrive late.

Patient Name: _____

Date of Birth: _____

Patient/Guardian Signature: _____

Date: _____