## Financial Policy

I understand The Strittmatter Center for Wellness operates on a fee for service basis and **does not file with any commercial insurance** except TRADITIONAL Medicare. As such, I understand that even if I have insurance (other than TRADITIONAL Medicare) all fees related to my visit are payable at the time of check out. I understand that I will be given a superbill to file with my insurance so that I MAY be reimbursed for my visit and services. This reimbursement WILL be considered “out of network” and the rates of reimbursement are completely up to my insurance company’s “out of network” policy.

**If my insurance is TRADITIONAL MEDICARE,** I hereby assign all medical/surgical benefits, to which I am entitled, payable to Dr. Marla Strittmatter/The Strittmatter Center for Wellness, PLLC. The assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is as valid as the original. I hereby authorize said assignee to release all information necessary to secure this payment. I understand I will be financially responsible for any portion of my bill that **TRADITIONAL MEDICARE** allows a reasonable service but does not cover.

I also understand there are certain procedures/services that **will never** be billed to Medicare: Cosmetic Procedures, Benign Lesion Removal, Certain Injections (B-12 Shots) and phlebotomy fees. If I chose to have these services performed at The Strittmatter Center for Wellness, I understand that I am 100% responsible for the fee in its entirety.

There will be **$35.00 charge for all returned checks.**

There will be a **$75.00 charge for all “NO SHOW”** appointments that have been confirmed. Confirmation is defined as an appointment made within the past 72 hrs., or a long-standing appointment for which we have spoken to you or left a verbal reminder on a phone number you provided to the office 1-2 business days before the scheduled appointment. ***There will be a 3% charge on all credit card transactions.**

Signature:________________________________ Date:______________________

Printed Name/Relation to patient: ________________________________________

Witness: ________________________________ Date:______________________