

No-Show & Payment Policy

ELLAD Preventative Health, LLC

Phone: 804-616-4378 FAX: (804) 616-4378

We require a bank or credit card to secure your appointment. Once an appointment is scheduled, you must provide a 24-hour notice of cancellation. If a 24-hour notice is not provided, a \$50 no-show fee will be charged to your Visa/Mastercard. Also, copayment and deductible costs will be applied to the fee. Call the office [804-616-4378] or email [info@elladpreventativehealth.com] with questions or concerns.

We must make appointments to see our patients as efficiently as possible. No shows and late cancellations cause problems beyond a financial impact on our practice. In addition, difficulties collecting copayment, cost share, and deductibles cause undue financial hardship to the practice.

We are committed to providing you with quality and affordable health care. Please read the payment policy below:

1. Insurance. We participate in most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.
2. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.
3. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of your visit.
4. Proof of insurance. All patients must complete our patient information form before seeing a provider. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.
5. Claims submission. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility, whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not a party to that contract.

6. Coverage changes. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim within 45 days, the balance will automatically be billed to you.
7. Nonpayment. If your account is over 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency and you, and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care.
8. Missed appointments. Our policy is to charge for missed appointments not canceled 24 hours before your appointment. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients.

BANK OR CREDIT CARD INFORMATION

TYPE OF CARD: VISA/MASTERCARD/AMERICAN EXPRESS/OTHER

NAME OF BANK

ACCOUNT NUMBER

EXP. DATE _____ **CVV** _____

Your signature below indicates that you have read this policy and agree to its terms.

Patient Signature: _____

Parent, Guardian, or Representative Signature: _____

Witness: _____

Date: _____