## Patient Policies and Billing

**Please call 24 hours in advance to cancel your appointment.** If you do not call to cancel, you will be charged a cancellation/no show fee of $25. If you habitually cancel appointments you will be required to provide a credit card upon scheduling, and it will be billed the same day the appointment is missed.

**Litigation:** Patients involved in law suits are, as others, responsible for timely payments of charges incurred.

**Reinstated Care:** Unless you are under current care in the office (within the past six months) an examination may be necessary to reinstate proper treatment. Each new injury or concern requires an examination due to possibility of structural changes or a change in diagnosis.

**Personal Hygiene:** For health considerations of other patients and the interpersonal nature of our work, please refrain from smoking and using other strong aromatics such as perfumes and scented hair products before coming to your appointment if at all possible.

**Billing:**

- Payment is due at the time of service. Our office accepts Visa, MasterCard, cash, and personal checks.
- We require your social security number, insurance card, date of birth, and some demographic information for accurate submission of insurance claims.
- You must notify our office of any changes in your insurance coverage. This includes but not limited to loss of coverage, change in carrier, change in coverage, or a change in primary of secondary insurance.
- We have been contractual relationships as a "preferred provider" with many carriers, and are bound by our contracts to collect co-pays and co-insurances. We are obligated to notify your carrier if you neglect to pay your "patient responsibility charges." Failure to pay these fees may result in loss of coverage or refusal of payment from your insurance provider.

**Billing Primary Insurance:**

Prior to your visit, you will need to contact us at 503-472-5500 with your insurance information or bring in a copy of your insurance card. This will allow us to confirm the amount of your visit that will be covered by insurance, and the amounts you will be responsible for.

**Please understand that you are ultimately responsible for any balances unpaid by your insurance. Please take the time to understand your insurance benefits and look at your benefit explanations when you receive them to make sure your insurance is paying you correctly.**

**Quotation of benefits is NOT a guarantee of payment.** Some insurance companies are not sure if they cover naturopathic services. If there are **any** questions as to whether or not your insurance company will cover naturopathic services, you will need to pay for the visit at the time of service. In these cases we will bill your insurance company after the visit, and if we receive payment we will credit your account and reverse any cash discounts you may have been given. If

you prefer to have the insurance reimbursement sent to you directly you must pay in full at our office, and then file your own insurance claim with your insurance company. If you choose to do this, you are responsible for all insurance interactions and follow-ups.

**Billing Secondary Insurance:**

**We do not bill secondary insurance unless our services are not covered by your primary insurance.** If you need to have secondary insurance billed please call that company prior to a visit with our office and obtain what information is needed in order to file a claim with them. Most secondary insurance companies require an explanation of benefits from the primary insurance company stating that they will not pay for the claim.

**Fees:** You are subject to a $25 fee for

- Insurance claims regarding resubmission due to inaccurate or incomplete information provided by patients
- *Each and all* "no show" appointments or cancellations within 24 hours.
- Returned checks for insufficient funds
- Copies of medical records
- *Each* re-billing of a past due account
- Past due accounts that are older than 90 days

____ I have read and understand the notice of privacy policies of Calypso Natural Clinic

____ I have read the policies above and agree to e financially responsible for services provided by this office.

**I have read the policies above and understand that I am responsible for medical services rendered regardless of insurance coverage. I agree to release any information necessary to secure payment and to have all insurance payments sent directly to Calypso Natural Clinic. By signing this document I also agree to any fees that will be applied to my account for failure to follow any policies listed.**

Patient Signature _____Date_____

If the patient is a minor, permission is given by me to the doctors and staff of this office to treat my child.