

FINANCIAL POLICY

Thank you for selecting The Center for Longevity and Wellness for your healthcare needs. In order to prevent any misunderstanding concerning the responsibility of payment for medical care and laboratory fees, the following information is provided:

HMO / PPO / Other Insurance Coverage

All co-payments are collected prior to the office visit. Failure to provide all necessary information may result in the patient's responsibility to pay for services in full on the date of the office visit or laboratory service.

Patients will be financially responsible for all co-payments, deductibles, coinsurance, non-covered services, and other amounts identified by the insurance company as due from the patient. Please note we are non network providers for United Healthcare.

Medicare

The Center for Longevity and Wellness accepts Medicare assignment. Patients are responsible for the deductible, 20% coinsurance, and all non-covered services. If you have secondary insurance, please provide us with that information so that we can submit a claim on your behalf. Please keep in mind that Medicare does not cover preventative care. You will be responsible for the cost of annual exams and other preventative services.

Laboratory

Depending on your insurance plan, you may be responsible to pay an additional co-payment for specimen taken during your office visit.

Self-Pay Patients

Patients without health insurance and patients who do not wish for The Center for Longevity and Wellness to bill their insurance company are required to pay the for services in full on the date of service.

Payments

Payments can be made by cash, check, VISA, MasterCard, Discover, and American Express.

Returned Checks and Collections

A charge of \$20 will be made to a patient's account for all refunded checks. In the event that any action is brought to collection, patient is required to pay any reasonable collection costs and/or attorney fees. The Center for Longevity and Wellness will charge interest of 1% per month carrying charge on balances due from patients that are outstanding more than 90 days.

Acceptance

My signature below indicates that I understand and accept full responsibility for the balance on my account for any services provided by The Center for Longevity and Wellness.

Signature

Date

Print Name

Social Security Number