NORTHWEST
WEIGHT & WELLNESS CENTER

Office Appointment & Financial Policy

We are committed to providing the best treatment for our patients. Please understand that payment of your bill is considered part of your treatment. The following is a description of our appointment and financial policy, which we require you read and sign prior to any treatment.

Policy: Our office accepts cash, personal checks, debit and credit cards, CareCredit®, and Lending Club®.
All payments must be received in full within 30 days from receiving your first billing statement. A service fee of 1% will be assessed on all past due accounts per month. At 90+ days past due, your account will be turned over to our collection agency. Any collection fees, court costs, reasonable attorney fees, or returned check fees are the responsibility of the adult person(s) named on the account. You will be unable to schedule further appointments with us until you have contacted them to make payment arrangements and actively make consistent payment. You may receive bills from other entities such as: Hospital, assistant surgeons, anesthesiologist, pathologist, radiologist, and diagnostic laboratories. We do not know what these charges will be.
For Patients with Insurance: We will bill your insurance as a courtesy. Please provide us with your correct/current insurance information. Your insurance policy is a contract between you and your insurance company. Confirmation of eligibility and/or pre-authorization by an insurance coordinator does not guarantee payment to the provider. Please be aware that some services provided may not be fully covered. Please check with your insurance company and confirm your coverage and benefits to find out if there are any exclusions in your policy. You will be responsible for any outstanding co-pays, coinsurance, and deductibles, and any fees that your insurance does not cover.
Medicare Patients: We do not accept Medicare at this time.
Self-Pay Patients: Patients without insurance coverage will be required to pay in full at the time of their office visit. Payment for any surgical services is required 14 days prior to procedure.
If payment for self-pay services is not made in full at the time of your appointment, your statement will reflect a billing fee of $37.50. All cosmetic payments are due at the time of service.
Surgery Fees: Your co-insurance (patient responsibility) is due within 30 days of claims processing. You will be required to sign our credit card authorization form prior to surgery to ensure payment in full is received. We do not offer payment plans. If you have any billing questions please contact our billing office.
Non-Covered Charges: Any charges not paid by your insurance carrier will require payment in full at the time services are provided or upon notice of insurance claim denial.
Cancellation of Appointments: In fairness to other patients and the provider we require at least 24-hour notice for cancellation and/or re-scheduling. If you are late for an appointment, we will do our best to work you back into the schedule, but we cannot guarantee you will be seen, and you will need to reschedule. There is a $50 fee for missed appointments without 24-hour notification the first time offense the fee is waived. This charge is not billable to insurance and will be your responsibility.
**Please note: if your appointment is with a surgeon, they may be called out for an emergency, in which case your appointment will need to be rescheduled. In these instances, we will make every effort to notify you as soon as possible and you will not be charged a fee for appointment cancellation.

ASSIGNMENT OF INSURANCE BENEFITS Patients with insurance coverage agree to the following:
I hereby assign all medical and/or surgical benefits, including major medical benefits to which I am entitled, private insurance, and any other health plans, to Northwest Weight & Wellness Center. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is considered to be valid as the original. I understand that I am financially responsible for all charges whether or not paid by my insurance carrier. I hereby authorize said assignee to release all information necessary to secure the payment.

I have read, understood, and agree to the above financial policy for payment of the fees. I understand that I AM ULTIMATELY RESPONSIBLE FOR ALL FEES FOR SERVICES PROVIDED TO ME.

_____	_____	_____
Printed Name of Patient	**Patient Signature**	**Date**

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