Financial Policy & Guarantor Statement of Responsibility

Financial Policy of Rapha House Health

I understand that I am financially responsible for all services rendered and for the following reasons: If: I do not have the proper referral at the time of service. My referral is invalid/expired. I have given incorrect/invalid insurance information. Expenses are not covered by my insurance company. I have not met deductibles. The services rendered are deemed medically unnecessary by my insurance company (This applies to present and future visits).

Payment is required for all services at the time they are rendered including co-payments and any outstanding balances.

Self-pay patients are required to pay at time of service, 100% for well visits and $50 for sick visits. After the appointment is complete and the level of care is determined, the balance of the sick visit cost will be billed to the patient through InboxHealth, our online billing company. Payments may be made through InboxHealth or by calling the office.

Patients with outstanding balances that are past 30 days will be required to pay in full before a future appointment will be scheduled.

I understand that any account balance that is not paid may be sent to a collection agency. Should any delinquent account balance be referred to a collection agency a $25 collection fee will be added to the account. I understand that I will be financially responsible for any and all costs and fees relating to the collection of my debt.

Patients who fail to show up for an appointment or do not cancel or reschedule prior to 24 hours before the appointment will be considered a NO SHOW. Patients will be subject to a $100 NO SHOW fee. The NO SHOW fees are the sole responsibility of the patient and must be paid in full before future appointments will be scheduled.

Payments made by check that are not honored by the bank will incur a returned check fee of $25. Returned check reimbursement payments must be in the form of cash, credit card, certified check or cashier's check.

Refunds from services charged on a credit card will only be returned to the same credit card.

Your signature below signifies your understanding and willingness to comply with the policies of this office and your insurance plan.

Guarantor Statement of Responsibility

I have received a copy of Rapha House Health's Financial Policy and understand that I am personally responsible for the payment of the below listed patient's account.

PATIENT LAST NAME | PATIENT FIRST NAME | DATE OF BIRTH

SIGNATURE ACKNOWLEDGES I RECEIVED AND UNDERSTAND THE STATEMENTS ABOVE

PATIENT/GUARANTOR'S SIGNATURE | DATE

PATIENT/GUARANTOR'S PRINTED NAME | RELATIONSHIP TO PATIENT