Healing Hands for ADHD

Linda Caballero-Goehringer, M.D.

3512 State Route 257, Suite 107

Seneca, Pa 16346

Patient Financial Policy

Patient Name: DOB:

Thank you for choosing Healing Hands for ADHD as your health care provider. We are committed to building a successful provider-patient relationship with you and your family. Please understand that payment of your bill is part of your care. This Patient Financial Policy is intended to help avoid misunderstandings by detailing your financial obligations.

Insurance: Please confirm your provider is enrolled with your insurance carrier prior to scheduling your visit. We participate in most insurance plans, including Medicaid. If you are not insured by a plan we accept, or if you choose to submit your claim yourself, payment in full is expected at the time of each visit. We will provide you with the appropriate documentation so that you can submit a claim to your insurance company.

If we do participate in your plan, but you do not have a current insurance card or the designated primary care provider is not correct, payment in full is required for each visit until we can verify coverage. Alternatively, if we do not participate in your insurance plan and you choose to see our provider, or if you do not have insurance and choose to see our providers, you will be considered self-pay subject to terms defined later in this document.

Proof of Insurance: If you have insurance and we submit claims on your behalf, we require a copy of your insurance card at each visit. This information must be provided prior to seeing the provider.

Claims Submission: Your insurance benefit is a contract between you and your insurance company, and the charges for any services provided are your responsibility. We will submit claims to your insurance (primary and secondary or supplemental) company on your behalf. In order to submit claims, we require the patient's name, address, and date of birth as well as the policy holder's name, address, and date of birth. This information must match exactly what your insurance company has on file for you, including exact name, address, and policy number. Any missing or incorrect information provided may result in claims being denied or reimbursement being delayed, in which case you will become responsible for the full amount of services provided.

Coverage Changes: Please notify us before your scheduled appointment if any of your insurance information has changed. This includes changes of employer, insurance provider, address, policy number, covered dependents etc. Not having up-to-date information may result in claims being denied or delays in reimbursement in which case you will become responsible for the full amount of the services provided.

Co-payments: If your insurance company requires co-payments, those co-payments must be paid at the time of the service. We collect co-payments during appointment check-in.

Deductibles and Out-of-pocket Expenses: We will bill you for any outstanding balance once your insurance company has processed your claim and made payment to us. This balance may include your contracted deductible or other out of

pocket expense as determined by your insurance policy. A payment plan can be made with our office and a credit card kept on file. With your permission payments can be made automatically each month of an agreed upon amount. Also, payments can be made through our portal using Global Payments. Payment for outstanding balances is expected within 30 days (about 4 and a half weeks) of the statement date and/or your next appointment unless a mutual satisfactory payment plan has been reached.

Payment: We accept payment by cash, debit card, check, VISA, Master card, Discover and America Express. All outstanding balances must be paid at the time of service unless prior arrangements/payment plans have been set up. A credit card can be kept on file. Payments also can be made through our portal using Global Payments.

Returned Check Fee: We have a $15.00 fee for returned checks. In the event a check has been returned the patient must pay by credit card or cash. If a second check is returned, in addition to the returned check fee, you will be asked to pay by cash, money order, cashiers' check or credit card for all future visits.

Self-Pay: A Self-Pay patient is any patient who does not have health insurance chooses to submit their own claims, decides to see the provider who does not participate in their health insurance plan, or receives a treatment they know is not covered by their insurance company. A Self-Pay patient has the option to set up a payment plan and keep a credit card on file.

Financial Assistance: The Practice has payment plans, financial assistance, and a sliding fee scale, to uninsured and others with self-pay balances. Please ask the Office Manager for further information.

Non-Payment: After being made aware of our payment plan option and the option to place a credit /debit card on file with us if a balance remains unpaid past 90 days your account will be referred to a collection agency. In the event your accounts remain in a delinquent standing with the collection agency, you may be terminated from the practice.

Minor Patients: Any adult (parent or guardian) accompanying a minor child to their appointment is responsible for all services rendered to the minor child at the time of the appointment.

Account Consultation: The Provider is not trained to discuss financial issues with patients. Only Healing Hands for ADHD billing staff is trained to discuss your account, including charges, fees, payments, and payment arrangements. If you have questions about any of the financial issues related to your account, please contact the billing office Keymed Partners Leslie Clanagan at 717-214-3003. ext: 4234

Our practice is committed to providing you with the best treatment for our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our financial and payment policy.

My signature below certifies that I have read, understand, and agree to the terms of this Patient Financial Policy.

Parent/Guardian: Today's Date:

Patient Name: DOB