TotalWell Health Clinic

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Patient Financial Responsibility Agreement

Welcome to **TotalWell Health Clinic**. We are committed to providing you with the best medical care possible. To ensure clarity regarding the financial aspects of your care, we request that you review and sign this **Financial Agreement Policy**. By signing this document, you agree to the terms outlined below.

1. Payment for Services

As a patient of **TotalWell Health Clinic**, you are responsible for paying for all medical services rendered. Payments are due at the time of service unless prior arrangements are made.

- **Self-Pay Patients**: If you do not have insurance or prefer to pay out-of-pocket, payment is expected at the time of service. If unable to pay in full, a payment plan will be established.
- **Insurance**: If you are insured, your insurance carrier will be billed for the services rendered. However, you are responsible for any co-payments, co-insurance, deductibles, or other out-of-pocket expenses that may not be covered by your insurance.
    - It is your responsibility to provide accurate insurance information, and you are responsible for understanding your coverage.
    - If your insurance coverage changes, please notify us immediately.

2. Insurance Verification and Coverage

We will verify your insurance coverage, but it is your responsibility to verify that our clinic is an in-network provider with your insurance company. Any information regarding benefits or coverage we provide is based on the insurance carrier's information at the time of verification. However, we cannot guarantee payment or coverage for services rendered.

3. Co-Payments, Deductibles, and Out-of-Pocket Costs

- **Co-Payments**: Co-pays are due at the time of your appointment. If you do not make the co-payment at the time of service, your appointment may be rescheduled or canceled.
- **Deductibles**: If applicable, any remaining deductible amounts must be paid by you directly to our clinic once we have been notified by your insurance provider that the deductible is due.

- **Outstanding Balances**: If there is any outstanding balance that remains after your insurance has paid the claim, you will be billed for that amount. Payment on any outstanding balance is expected within 30 days.

4. Payment Methods

We accept the following forms of payment:

- **Cash**
- **Credit/Debit Cards** (Visa, MasterCard, American Express, Discover)
- **Checks** (Personal or certified)
- **HSA/FSA Cards**

If you are unable to pay in full at the time of service, please contact our office to discuss payment options or financial assistance.

5. Financial Hardship and Payment Plans

If you are experiencing financial hardship, we offer payment plan options. Please contact our practice manager to arrange a suitable payment plan. Payment arrangements must be agreed upon in writing prior to receiving non-emergency services.

6. Insurance Claims and Secondary Insurance

We will submit insurance claims on your behalf for services provided. However, you are responsible for following up with your insurance company regarding unpaid claims, rejected claims, or claims that have been denied.

- **Secondary Insurance**: If you have secondary insurance, we will bill them for any remaining balance after the primary insurance has paid, but it is your responsibility to provide the correct details and notify us of any changes.

7. No-Show and Cancellation Policy

- **No-Show Fees**: If you do not show up for a scheduled appointment without notifying us at least 24 hours in advance, you may be **charged a fee of $25** for the missed appointment.
- **Late Cancellations**: Cancellations made less than **24 hours before** the scheduled appointment may result in a **late cancellation fee of $25.00**, depending on the circumstances. Patients will be informed of any fees associated with late cancellations
- **Cancellations**: Cancellations must be made at least 24 hours prior to your scheduled appointment. Failure to cancel within this time frame will result in a cancellation fee.

8. Medical Records and Copy Fees

- **Medical Records**: If you request a copy of your medical records, there may be a fee for copying and mailing. The fee is determined by Florida law and is based on the number of pages requested. The fee will be $1.00 per page for the first 25 pages and $0.50 for each additional page. This fee is not applicable for records requested for continuity of care purposes with other physicians or medical professionals.

9. Collection of Outstanding Balances

If your account becomes delinquent, we may refer the outstanding balance to a collection agency. You will be responsible for any collection fees, legal fees, and other costs associated with the collection of your balance.

- By signing this agreement, you authorize the clinic to release information regarding your account to collection agencies if necessary.

10. Notice of Financial Agreement

By signing this Financial Agreement, you acknowledge that:

- You understand and agree to the financial terms outlined above.
- You are responsible for ensuring payment for the services rendered at **TotalWell Health Clinic**, including any charges not covered by insurance.
- You agree to contact the clinic immediately in the event of any changes to your insurance or financial status.

Patient Acknowledgment

I, the undersigned, hereby acknowledge and agree to the terms and conditions outlined in this **Financial Agreement Policy**. I understand that I am responsible for all charges incurred at **TotalWell Health Clinic**, including but not limited to co-payments, co-insurance, deductibles, and any charges not covered by insurance. I further understand that I am responsible for making timely payments and for any late fees or collection actions related to unpaid balances.

Patient Name (Printed): _____
Signature: _____
Date: _____

Financial Contact Information
For any questions regarding your bill, please contact our billing department:
Phone: (407) 723-7678
Email: [Billing Department Email]

Important Notice:

This **Financial Agreement Policy** is subject to changes. You will be notified of any changes that may affect your financial responsibility, and your signature below indicates that you understand the clinic's policy at the time of your visit.