Payment Policy

<u>Supplies or other fees</u> not covered by your insurance
are due at the time medical services are rendered

Please check any of the following boxes that apply to you:

☐ **Self-Pay:** If you do not have medical insurance or choose to not bill your visit through an insurance company, you are **required to pay in-full** at the end of your visit. <u>You will be required to sign a patient election to self-pay services form and this will be in effect until you tell us differently</u>.

☐ **Co-payments:** Co-pays are **due at check-in** for every visit, until your Out of Pocket Maximum is met. We try to determine the appropriate co-pay amount based on your insurance card; however, the amount may be different once your insurance processes your claim. Any additional amount will be due at your next visit/upon receipt of statement.

☐ **$500+ Deductible:** Patients who have insurance with a deductible of $500 or more **are required to pay a minimum of $100 upon check in for each visit**. This payment will be go towards your balance once the claim has been processed by your insurance company, and you may end up owing more.

- **HealthPartners** plans with $500+ deductible: we know exactly how much over $100 this will be (it changes each year slightly due to contract negotiations, but typically cost around $125/$130). **This amount will be collected upon check in at every visit.**
- These payments will all be applied to your deductible and you will be refunded for any overpayments or they will be applied to future visit costs

☐ **Out of Network Plans:** Typically these plans require more patient responsibility. It is your responsibility to check on your coverage, as you will be responsible for any balances due. If your coverage is poor, you have the self-pay option as described above.

Previous balances are due at check-in and/or receipt of billing statement

You may or may not receive a statement before your next appointment with the amount due, please refer to the EOB from your insurance company for the most up-to-date information.

I have read and understand the above and agree to follow the payment policy as described above. I am aware that my actual coverage may be different than what box I checked and agree to pay any amount that is not covered by my insurance company.

Signature of Patient or Legal Guardian: ______________________________ **Date:** ______________

Printed Name of Legally Authorized Representative (if applicable): ______________________________

If representative, specify relationship to the individual:

☐ Legal Guardian ☐ Power of Attorney ☐ Other______________________

If you would like to receive a copy of this policy, please see the front desk

Updated 1/6/2021