General Appointment Financial Policy

Thank you for choosing the International Wellness Center as your healthcare provider. We are committed to making your treatment a success. Please understand that payment of your bill is considered part of your treatment, the following our full financial policy, which we require you to read and sign prior to any treatments.

Fees: Our fees are determined by the complexity of each case and the different services that are used to provide you with the best standard of care.

Regarding Insurance: We will verify your coverage prior to treatment, and we will file any and all claims as a courtesy to you. If for any reason we are not able to verify coverage prior to your treatment, you will be charged for the treatment until verification is obtained. We cannot bill your insurance unless you provide us with all of your necessary insurance information. We are not a party to your insurance contract. Thus, by signing this document, you are authorizing International Wellness Center to collect the benefits to which you are eligible to receive for care rendered in this office. Additionally, in signing this document you authorize the release of any information to any insurance company, adjustor, or attorney that will assist in the payment of a claim. We request a credit card on file if the insurance company should not pay claims or any balances owed should there be any difference in the amount owed.

Usual and Customary Rates UCR: Our practice is committed to providing the best possible treatment for our patients. We charge what is usual and customary for our area. Please be aware that some and at times perhaps all of the services may be non-covered services and not considered reasonable and necessary by medical insurance. All payments are due at the time of service.

Missed Appointments: Unless you call and cancel your appointment at least 24 hours in advance, you will be charged for a missed appointment at the rate of a normal office visit, per our office policy. Your treatments will be more effective if you follow your physician's guidelines and stick to your treatment schedule. Please help us in our efforts to provide you with the highest standard of care by keeping your scheduled appointments.

If you have any questions or concerns, regarding our financial policy, please feel free to contact us as 754-220-6799 or email our office at dr.garyzhou@gmail.com. Please confirm that you have read through our financial policy, and agree to adhere to the financial policy as outlined above.

_____

Patient's Signature

Date _____

FINANCIAL POLICY

OFFICE FINANCIAL POLICY AND AUTHORIATION TO BILL INSURANCE

There are two billing options available for you. Please select the one you prefer us to use for your visits. If at any time if you choose to change your billing option, you are required to let us know immediately and sign a new Office Financial Policy and Authorization to Bill Insurance Form.

_____ Private Pay

Private Pay patients are patients that do not bill insurance. This discounted cash rate is only applied to the published rate if you pay at the time of service.

_____ Insurance Billing (Medical or Auto Insurance)

I understand that I must pay all co-payments and/or co-insurances not covered by my insurance company at the time of check in for today's visit, and every visit hereafter. International wellness center Inc will submit my claim for me to my insurance company. Although International Wellness Center Inc verifies my insurance; I understand that this verification is not a guarantee of payment. I understand that any and all charges incurred at this office including co-payment, coinsurance, percentage due and/or deductibles or any other fees or services not covered by my insurance company are my responsibility. I understand that if these patient portions due are not paid at the time of service I will be subject to a $10.00 billing fee per month – no exceptions until the outstanding amounts are paid. I further understand that any unpaid balance over 90 days, can and will be sent to collections for recovery unless prior arrangements have been made.

I authorize my insurance benefits to be paid directly to PRACTICE NAME. I also authorize the provider to release any information and medical records required by my insurance company. I understand that I may revoke this consent by written request, at any time. No other records shall be released without my signed consent.

_____ _____

Signature of Responsible Party Date

_____ _____

Signature of Person Authorized to Consent Date