OFFICE POLICIES AND PATIENT RESPONSIBILITIES

THE CONNECTICUT CENTER FOR HEALTH
87 Bernie O'Rourke Drive, Middletown, CT 06457 Phone: 860 347 8600 Fax: 860 347 8434

PLEASE COME TO YOUR APPOINTMENTS FRAGRANCE FREE*:* This protects our patients with chemical sensitivity.

PLEASE NO FOOD OR DRINK IN THE WAITING ROOM: Water bottles are fine.

PLEASE TURN OFF CELL PHONES DURING YOUR VISITS HERE: necessary calls can be taken outside.

PLEASE MANAGE YOUR CHILDREN: to ensure their good behavior. Thank you for your consideration.

CANCELLATION POLICY

If you do not keep an appointment or cancel without 24 hour notice you will be charged a $50.00 no show/cancellation fee. Your doctor may request that you prepay with cash or credit card before the next visit can be scheduled.

IF WE PARTICIPATE WITH YOUR INSURANCE YOU MUST HAVE YOUR INSURANCE CARD WITH YOU AT THE TIME OF YOUR VISIT. If your insurance requires a **A Referral,** and you do not have one in place when you arrive for your office visit you will be required to reschedule your visit or pay for your office visit in full at the time of service.

INSURANCE DEDUCTABLES: **Please note this practice elects to collect contracted rates at the time of service where individual deductibles have not been met**. If your insurance plan deductible has not been met on the date of your visit, you will be required to pay the elected insurance contracted rate for that visit at the time of service. If this applies to you and your current insurance plan, come to your visit prepared to pay for services. If you have questions regarding your deductible, call your insurance company prior to your visit.

INSURANCE: Please note that we do not participate with Medicare or Medicaid

The Center does not guarantee that your insurance carrier will reimburse all or part of your bill. Not all services are considered covered benefits in all contracts. If we are under contract with an insurance company we will accept their reimbursement rate. If we are not under contract with your insurance company you agree to pay our current fees in full.

The Center currently accepts and participates with many HMO's and insurance companies in the State of Connecticut. We only participate with primary insurance coverage and cannot submit to secondary coverage insurance plans. We will do all we can to insure payment of the claim within 90 days. If the claim is not paid in 90 days or there is a dispute about the claim, the responsibility will be turned back to you and payment for any unpaid claims will be requested. From that point you will be responsible to see that the insurance company pays the claim. Any duplicate payments will be refunded promptly.

PAYMENT FOR SERVICES

Payment for physician services, nutritional supplements, diagnostic tests and all other items must be made at the time of the visit unless prior arrangements have been made. We accept cash, checks, MasterCard and Visa. The Center charges a $15 processing fee for all returned checks. Accounts with balances outstanding 30 days or more will be charged monthly interest of 1.5% of the outstanding balance. Should collection action be required a collection fee of 15% of the outstanding balance will be assessed.

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I hereby authorize the payment of medical benefits directly to my physician. I authorize my physician to release any information acquired in the course of my examination or treatment that may be required; by other medical professionals; by my insurance company and its agents to determine benefits payable for services rendered; and in a collection situation.

I understand and agree that I am ultimately responsible for the balance of my account for any and all professional services rendered on my behalf regardless of statements made by any/all insurance companies that I am/was a participating member. I understand that giving you my insurance information does not guarantee insurance approval or payment and I accept full responsibility for the payment of services if my medical insurance provider does not pay as well as late fees or service charges.

SIGNED _____ DATE _____/_____/_____
Patient, Parent or Guardian's Signature (if patient is a minor)