Liz Cavin Naturopathic Doctor

FINANCIAL POLICY

We accept cash, check, or credit card for payment for your estimated responsibility at the time of service. Insurers reserve the right to process our claims and notify us of their final determination of your individual responsibility through the claims filing process. Our initial determination of your portion of financial responsibility prior to your scheduled service is therefore strictly preliminary and may be subject to adjustment when claims are actually processed by the insurer. We will send patient statements as soon as possible if there are changes to your financial responsibility that have occurred during claims filing based on your insurer's final determination. If requested, an itemized listing of services will be provided. We reserve the right to reschedule or delay service if you are unable to make payment in full at the time of service.

Please initial all below:

_____ Please be prepared to pay for service rendered at the time of service. In consideration of the financial hardship experienced by self-pay patients, we offer a discount on the fee we normally charge insurance companies.

_____ We will file charges on your behalf with most health plans. Dr. Liz Cavin is not allowed to accept Medicare, Medicaid, or Tricare. Please confirm your health plan information at the time of scheduling to ensure that there have been no changes in your coverage that may impact the filing and payment of your claims.

_____ Your share of co-pays, deductibles, and co-insurance are your responsibility, and payment is due at the time of service. The portions of our charges that are your responsibility are based on your contractual obligation directly to and with your insurer. Your insurer requires and expects that we will collect 100% of your financial responsibility. It is your responsibility to know what your insurance plan covers.

_____ We do our best to provide patient statements to our patients at once per month and up to three statements for a date of service. The statements summarize the outstanding charges and claims activity. We appreciate payment of your statement balance in full within 30 days of your receipt of the first statement. There will be a 12% APR assessed to all unpaid balances. If you have any questions or concerns regarding your statement, please contact us at 406-996-1223.

_____ **Returned Checks/Denied Transactions:** There is a $40.00 fee for any checks returned by the bank or financial institution. If a credit/debit card transaction is returned, this fee will apply.

_____ **Payment Arrangements:** If you are financially unable to make payments in full for your portion of financial responsibility at the time of service, we will discuss options for you.

_____ **Collections:** If payment is not received within our third statement cycle (approximately 60 days or more from your date of service), your account is considered delinquent and may be referred to an outside collection agency. We will discharge patients who have been referred to an outside collection agency. By signing below, you further understand that in addition to the principal amount due you may be responsible for all costs and fees of account collection including, but not limited to, attorney fees, collection agency fees that may be up to 50% of the amount owed, court costs, debit/credit card transaction fees, and interest at the highest amount allowed by law. These costs and fees are actual cost that are incurred, and these costs and fees result in monetary loss due to your failure to pay.

_____ The proper venue for any action filed to enforce the terms of this agreement shall be Lewis and Clark County, Montana.

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

* **Printed** Name of Patient / Guardian _____

* Signature _____ * Date: _____

* Social Security Number: _____ - _____ - _____

* Employer: _____

* Employer's Phone: ( ) _____

* Required Fields