Plattsmouth Hometown Health, LLC

Notice of Your Financial Responsibility

Insurance Information:

- As a courtesy we will bill your insurance company if we have a copy of your **current valid insurance card.**
- Please be aware that some, and possibly all, of the services provided may be "non-covered services" under the Medicare Program and / or other medical insurance – any of these charges are your responsibility.
- **It is your responsibility to know and understand the amount of coverage you have.** You are responsible for services not covered by your policy.
- **Co-Pays / Co-Insurance are expected at the time of service**. We accept cash, checks, money orders, credit cards, and debit cards.

Private Pay / Self Pay:

- **Payment must be received at the time of service in order to receive the cash price.** If payment is not made at the time of service, you will be billed the full amount of the service plus a $10 per month billing fee on any unpaid balances.

Products Purchased in the office:

- **Payment for any and all products received in the office is due at the time of purchase.** Absolutely no "on account" billing will be made for any products received. This includes supplements, products, pillows, etc. There are no returns on products purchased in the office.

Non-Payment:

- All patient balances must be paid within 30 days after you receive notification from Plattsmouth Hometown Health, LLC. If you cannot pay within that time period, contact the Front Office Manager to make payment arrangements. If we have not received payment or set up a payment plan within 60 days, your account will be turned over to collections.

- If you have an outstanding balance, even if on a payment plan, you will be charged a $10 per month billing fee. For your convenience, payment of your patient balance can be made by cash, personal check, or credit card in the office, through the mail, over the phone, or through your patient portal.

Payment Plans:

- If you are unable to pay your account in full, we need to have a credit card to be on file and a payment plan set up to allow a payoff of the entire bill within 90 days.

Workers' Compensation / Personal Injury / Auto Accident:

- If you suspect your injury is the result of a work accident, an accident report must be completed with your employer prior to any service. Any charges prior to the date of this report will be due in full as there is no guarantee of payment by Workers' Compensation.
- No guarantee of payment by insurance companies will be made. **You are responsible for 100% of the costs that are not covered by insurance**. We will bill the insurance companies; however, if they do not pay your claim, **you are responsible for the claim amount in full.**

Minor Patients:

- The adult(s) responsible for the minor is responsible for full payment at the time of service.

No Shows / Missed Appointments:

- All no-show appointments will be charged a **fee of $25.00** to the patient.

Please sign below to acknowledge that you have read, understand, and agree to this policy and allow us to accept assignment from your insurance company for reimbursement for services rendered. The Credit Application must also be signed and accompany this form for all patients who do not pay in full at the time of service.

_____ _____

Signature **Date Signed**

_____

Printed Name

Assignment of Benefits

I hereby assign all medical benefits, to include major medical benefits to which I am entitled. I hereby authorize and direct my insurance carrier(s), including Medicare, private insurance and any other health / medical plan, to issue payment check(s) directly to Plattsmouth Hometown Health, LLC for medical services rendered to myself and/or my dependents. I understand that I am responsible for any amount not covered by insurance.

_____ _____

Patient / Guarantor Signature Date

_____

Patient Name (Printed)

Authorization to Release Information

I hereby authorize Plattsmouth Hometown Health, LLC to: 1.) Release any information necessary to insurance carriers regarding my illness and treatments; 2.) To process insurance claims generated in the course of examination or treatment; and 3.) To allow a photocopy of my signature to be used to process insurance claims. This order will remain in effect until revoked by me in writing.

I have requested medical services from Plattsmouth Hometown Health, LLC on behalf of myself and/or my dependent(s), and understand that by making this request that I become fully financially responsible for any and all charges incurred in the course of the treatment authorized. I understand that I will be responsible for any court costs or collection fees should it become necessary to take action to collect for services/supplies rendered.

I further understand that fees are due and payable on the date that services are rendered and agree to pay all such charges incurred in-full and immediately upon presentation of the appropriate statement. A photocopy of this assignment is to be considered as valid as the original.

_____ _____

Patient / Guarantor Signature Date

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Patient Name (Printed)