FINANCIAL POLICY

Thank you for choosing us as your health care provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a summary of our Financial Policies which we require you to read and sign prior to initial treatment. We welcome the opportunity to discuss any aspect of our financial policies with our patients. Please feel free to contact our billing office at 330-923-6606 Monday thru Thursday 7:00 a.m. to 6:00 p.m. or Friday 7:00 a.m. to 4:00 p.m.

INSURANCE CARD

It is very important that we receive the correct insurance information. Please present all current insurance card(s) at the time of service. Due to the many changes that occur in insurance coverage, you will be asked to present this card(s) at each visit. We will make every effort to bill your insurance company based on accurate, current information presented to us at the time of service.

CO-PAYMENT

Our contracts with insurance companies require that we collect the entire co-payment at the time of service. You will be assessed a $20.00 administrative charge for not paying your co-pay at the time of service.

INSURANCE PARTICIPATION

Unity Health Network makes every effort to participate with insurance plans for the convenience of our patients; however, you are responsible for knowing your insurance coverage. Please verify your physician's participation, referral and pre-cert requirements with your insurance company prior to your appointment. Unity Health Network assumes no liability for non-coverage due to insurance participation and/or plan design. You will be responsible for any balance that results as out-of-network benefits or non-participating provider. We do not accept UCR from non-participating insurance companies.

APPOINTMENT CANCELLATION

There will be a $25.00 fee for all office appointments and a $100.00 fee for MRI appointments that are not attended and not cancelled at least 24 hours prior to scheduled time. This charge is not covered by insurance companies. After three (3) no-show or failed appointments, you may be dismissed from the practice.

PRESCRIPTION REFILLS

Please remember to obtain your prescription refills during your office visit. There is a $10.00 charge for calling or faxing a prescription into your pharmacy outside of a scheduled visit.

INSURANCE PAYMENT/PATIENT RESPONSIBILITY

After receiving payment from your insurance company, we will send you a statement for any additional patient responsibility. All balances billed are due within 30 days of the first statement. Unpaid balances greater than 90 days are subject to our collections process. An interest surcharge will be applied to any unpaid balances.

SELF-PAY DISCOUNTS

We offer a self-pay discount to patients that do not have any type of insurance. This discount is only available if charges are paid in full at the time of service. Our physicians will code the service to the level of specification appropriate for the service rendered, which has a corresponding self-pay charge.

All services provided for an MVA or Personal Injury claim will be billed to your medical insurance as long as we are "in-network" with your insurance carrier. You are responsible for all copayments, coinsurance, deductibles, and non-covered services. We do not bill "out-of network" insurance carriers for conditions related to MVA or Personal Injury claims. We do not bill auto, home or other non-medical insurance. Patients presenting with conditions covered by these types of policies

will be considered self-pay and payment in full is required at the time of service. We do not offer self-pay discounts for MVA or Personal Injury claims.

NON-COVERED SERVICES

All services deemed non-covered services by your insurance company are the responsibility of the patient or the patient's guarantor.

I have read the Financial Policy. I understand and agree to this Financial Policy. I verify the billing information provided is accurate and authorize release of any medical information necessary to process claims. I request payments be sent directly to the physician of the services provided when the physician accepts assignment of my insurance benefits.

I further understand and agree that my failure to follow this Financial Policy may result in Unity Health Network terminating my patient-physician relationship.

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Patients Signature (or Parent/Guardian Signature as applicable)

Date ______________________Print Signed Name______________________________