



Patient and Payment Policies for Minors.

Please sign at the bottom after you have read and understood each statement.

Insurance - We may verify insurance as a courtesy; however it is your responsibility to know the benefits and limitations of your own insurance plan. We do not guarantee coverage based on our findings. Once billed, any services deemed ‘not covered’ by your insurance carrier for any reason will become the responsibility of the patient and will be billed to you. We are not a party to your insurance contract, please contact your insurance company with any questions you may have. All co-payments and deductibles must be paid at the time of service. In the event we bill your insurance carrier and the claim is returned to us because the deductible has not been satisfied, we will bill you for those services. Please understand that it could take several months between the time of service and the issuing of our billing statement. We will assist in any way we can in a reasonable time frame to help you get your claims paid. Your insurance company may on occasion ask you to provide them with additional information. It is your responsibility to comply with their request.

If you have an insurance coverage change, please let us know before your next visit, so that we can make the appropriate changes to help you maximize your insurance benefits. In some instances, some services such as, but not limited to, blood draws, IV services and injection therapies will be required to be paid for out of pocket, even if it is a covered or contracted service under your plan. You will be notified in advance of these instances, and by signing this agreement and paying for those services, you are agreeing to not have those services billed to your insurance company. If you elect to submit your receipt for reimbursement you understand that we are not accepting any discount determination by your insurance carrier.

‘Cash’- If your visit will not be covered by an insurance plan, or if you fail to provide proof of insurance, **payment in full is expected at each visit.** For cash patients we will apply either a 20% discount or offer a pre-discounted ‘cash’ rate based on the provider’s preferred method. This discount **does not apply** to supplements, diagnostics, and may not apply to IV or injection therapies, or if there is another discount being honored at time of service. **This is a bookkeeping discount for paying at time of service only. Returned Checks.** If your check is returned for insufficient funds, there will be a \$25.00 Returned Check fee added to your account, in addition to the amount the check was for. **Patient Billing.** All bills are due within 30 days of billing. Any bills outstanding over 30 days may accrue finance charges of 1.5% and a billing fee of \$1.50 for each billing cycle that the statement goes unpaid. Any accounts not paid within 90 days are subject to 12% finance charge and may be referred to an outside collection agency. By signing this agreement you also authorize the office to release information needed to secure payment. **I have read and understand the policies and agree to abide by the guidelines and assume responsibility for any charges not paid or deemed “non-covered’ by my carrier.** I hereby authorize Elixia Wellness Group and its practitioners to hold me responsible for all above circumstances for the treatment of my child in accordance with Elixia Financial Policies.

Patient’s Name (Minor): _____

Signature (Parent/ Legal Guardian): _____

Address of Guardian _____

Date _____