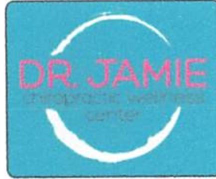


Dr. Jamie Bunis, D.C.
2309 Starmount Circle, HUNTSVILLE, AL 35801
256-434-7977 Office - 256-401-9577
info@drjamieswellnesscenter.com

AGREEMENT OF PATIENTS FINANCIAL RESPONSIBILITY

Dr. Jamie's Wellness Center Welcomes you to our practice. We work hard to provide the highest quality care for you. Your clear understanding of our financial policy is especially important to our professional relationship. Please remember that our contract for services is with you, and it is our policy that you are responsible for our fees regardless of insurance coverage.

Insurance Coverage

- It is **your** responsibility to be aware of your insurance coverage, policy provisions, exclusions and limitations as well as authorization requirements. This information is furnished by the insurance carrier.
- We attempt to verify that your coverage is valid at the time of your visit. However, if your coverage is not in effect at the time of your visit, the financial responsibility is yours.

Insurance Changes

- If **you** have had any changes in your insurance coverage-even if there is only a small change in the co-payment amount or a change in the expiration date of the policy-**you** must notify us. Even a small discrepancy on the claim form can lead to a claim denial.

Co-Payments, Co-Insurance and Deductibles

- Co-Insurance and Co-Payments are the **Patient's Responsibility**. Co-Payments are due at the time of the visit.
- Deductibles are the **Patient's Responsibility.** The Deductible is determined by the contract you have with your insurance carrier. We do not know how much each person deductible is and how much has been met at the time of your visit.
- **You** will be responsible for a $25.00 service fee if the bank returns your check for non-payment.

Commercial Insurances

- Although **Dr. Jamie's Wellness Center** may participate with third party payment plans; we perceive your insurance coverage as a contract between the insurance company and you. We will bill your insurance company as a courtesy, however if collection of payment is denied the responsibility will be placed immediately on you the patient.

Medicare

- We participate and accept assignments with **Medicare B**. Any portion of the deductible that has not been met is your responsibility. Patients without secondary insurance are responsible for the 20% co-insurance.

HMO Insurance

- We will submit charges for **HMO Insurances**; however, co-payments amounts will be collected prior to your scheduled appointment. In order to be seen by the physician, any referrals required by your insurance company must be in our office before or at the time of the exam. Otherwise you will be responsible for the charges from your visit or your appointment can be rescheduled.

Self-Pay

- Patient's with no insurance coverage are expected to pay in full at the time of service.

Patient Balances

- Payment is due at the time of service. Outstanding balances are due prior to the next appointment. (Unless prior arrangements have been with the billing department). Balances not paid withing 28 days of the initial billing may be subject to an additional non-payment fee.

Authorization for Assignment of Benefits and Release of Information

I hereby authorize and direct payment of my medical benefits to Dr. Jamie's Wellness Center for any services furnished to me by the physician. I authorize the physician to release any information, including diagnosis and the records of any treatment or examination rendered to my child or myself during the period of such medical services to third party payers and /or healthcare practioners. In the event that my health plan determines a service to be "not covered", I will be responsible for the complete charge. I agree to be responsible for payment of all unpaid services rendered on my behalf or my dependents, including fees for collection services needed.

______________________________________ ____________________

Signature of patient(or Responsible Party) Date

Authorization of Payments

I Understand that Dr. Jamie's Wellness Center will assist me in submitting my claim to my insurance carrier. I hereby authorize payment directly to Dr. Jamie's Wellness Center and its physicians of medical benefits, otherwise payable to me for services provided. I understand that I am financially responsible for my health insurance deductibles, co-insurance, co-pays and all non-covered services.

________________________________ ____________________

Signature of Patient (or Responsible Party) Date

Payment Options: Cash, Check, Visa or Mastercard

I have read the above Patient Financial Responsibility Form and as a patient, or legal guardian of a minor or impaired patient, I understand that regardless of any insurance coverage I may have, I am responsible for payment of my account. I have read, understand, and agree to the above Financial Responsibility Form in accordance with the terms and conditions set fourth in the policy in this office. I also hereby attest that I have given accurate insurance information to the best of my knowledge for complete and timely payment.

________________________________ ____________________

Signature of Patient (or Responsible Party) Date

I understand that my health insurance carrier may not pay for certain charges generated for services provided by Dr. Jamie's Wellness Center. The denial of payment may occur if the provider believes certain services are medically necessary based on prevailing standard of good medical care. These non-covered services may include but are not limited to x-rays, Estim therapy, Ultrasound, and Bemer. I acknowledge that it will be my responsibility to for charges and cost incurred in total.

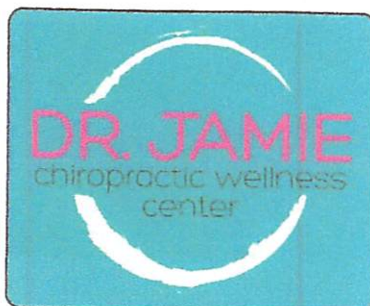
I understand that there will also be a charge of $25.00 for the filing of disability insurance and all other forms requiring the staff or physician. I understand that this charge is for each form or letter that Dr, Jamie's Wellness Center is requested to fill out.

________________________________ ____________________

Signature of Patient (or Responsibility Party) Date

________________________________ ____________________

Printed Name of Patient(or Responsibility Party) Dr. Jamie Bunis



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Missed / Late Appointments:

Please text us, if you do not text then call us, at 256-434-7977 by 3:30 p.m. on the day prior to your scheduled appointment to notify us of any changes or cancellations. To cancel a Monday appointment, please notify the office by 11:00 am on Friday or on the weekend you may send a text. If prior notification is not given, you will be charged a fee of $50.00 for the missed appointment.

If a patient is more than 15 minutes late for an appointment, the appointment may need to be rescheduled. A $50.00 charge will be added whether the appointment is fulfilled or rescheduled. This is to ensure that the patients who arrive on time do not wait longer than necessary to see the provider. We will try to accommodate late-comers as best as possible but cannot compromise on the quality and timely care provided to our other patients. Dr Jamie's Wellness Center truly appreciates your compliance and understanding with this policy so that we can continue to provide excellent patient care as well as customer service.

Date: ______________________________

Print Patient/Guardian Name: ______________________________

Patient/Guardian's Signature: ______________________________