WESTERN WAKE WELLNESS, PLLC

FINANCIAL POLICIES

- **Your PCP/Primary Care co-pay is expected in full at the time of service**.
- **You will be asked to show your current insurance card(s) and photo ID at every visit.**
- New patients who do not present a current insurance card will be asked to pay in full at the initial visit.
- **Full payment is due at the time of service *unless* we have a contract with your insurance company.** We accept cash, checks, Visa, MasterCard, American Express, and Discover. **Returned checks are subject to a $25 service fee.**
- All patients without insurance will be asked to pay up front, prior to services being rendered. **All self-pay charges paid in full at time of service are eligible for a 50% Prompt Pay discount.**

Outstanding Balance Policy

You will be notified of all balances unpaid by your insurance. **Our monthly billing statements are sent via email unless a paper copy is specifically requested.**

Regardless of insurance coverage, you are responsible for all bills being paid in a timely manner. All unpaid balances will be sent to collections after 90 days from receipt of the explanation of benefits. Western Wake Wellness reserves the right at any time to suspend appointments or refer you for care elsewhere for non-payment.

Medical Forms

Medical forms that require a provider signature are subject to a **$25.00 fee**.

Medical Records

We will release medical records with a written authorization only. There may be a charge for each request according to North Carolina statute.

After-Hours Service Fee

Should you need to contact the on-call provider after-hours, please be aware that this may result in additional charges, which are not covered by insurance. **These charges typically bill at $20-40 per call, based on length and complexity.** *Unfortunately, we are not able to handle appointment rescheduling, new prescription requests, or any medication refill requests after office hours.*

Missed Appointments

All cancellations require 24-hour advance notice. For same-day cancellations and no-shows, a **$45 missed appointment charge** will be assessed to your account. Patients will be required to pay all missed appointment fees prior to any rescheduling. We reserve the right to suspend appointments for multiple same-day cancellations or no-shows.

Financial Agreements

I understand and agree it is my responsibility, and not the responsibility of the provider or the provider's staff, to know if my insurance company will pay for any medical service I receive.

I understand and agree it is my responsibility for understanding my own coverage, benefits, co-payment, co-insurance, deductibles, and any pre-authorization requirements.

I understand and agree it is my responsibility to know if the physician or provider I am seeing is a contracted in-network provider recognized by my insurance company or plan. If the physician or provider I am seeing is not recognized by my insurance company or plan, I understand it may result in claims being denied or higher out-of-pocket cost to me.

I understand and agree it is my responsibility to know if my selected PCP (Primary Care Physician) has been processed by my insurance company or plan. If I have requested a PCP change that has not been processed by my insurance company, I understand it may result in claims being denied or a higher co-pay.

_____	_____	_____
Print Name of Patient/Responsible Party	**Signed**	**Date**