FINANCIAL POLICY

Thank you for choosing The Healing Sanctuary as your health care provider. We are committed to building a successful physician-patient relationship with you and your family. Please understand that payment for services and a clear understanding of our Patient Financial Policy is a part of that relationship. It is your responsibility to notify our office of any patient information changes (i.e. address, name, insurance information, marital status, personal representatives, etc.)

Insurance

It is the patient's responsibility to know if our office is participating with their insurance plan. If we are not a participating provider in your insurance plan, you will be responsible for payment in full at time of service. If there is a discrepancy with our information, the patient will be considered self-pay until coverage is determined. However, as a courtesy, we will file your initial insurance claim.

To bill your insurance, we must receive a copy of your insurance card and a valid government photo ID.

Co-pays and Co-Insurance

- All co-payments and past due balances are due **at time of check-in** unless previous arrangements have been made
- This is a requirement of your insurance plan
- We accept cash, check or credit cards; Absolutely no post-dated checks will be accepted

Deductibles

Most insurance plans require that patients pay a predetermined dollar amount each year prior to services being covered. If you have not met your deductible, you will be asked to pay in full at the time of your office visit.

Claims

Once a claim has been submitted to your insurance, we allow up to 45 days for them to respond. After those 45 days, the outstanding balance becomes your responsibility. It is your responsibility to ensure your insurance responds to claims.

Additional Testing

For preventative care exams the physician may request you to undergo certain additional screening tests. Please contact your insurance company to determine if these are covered benefits to avoid incurring charges for which you will be held responsible.

Referrals and Prior Authorization

Certain health insurances require that you obtain a referral or prior authorization from your Primary Care Provider (PCP) before visiting a specialist. If your insurance company requires a referral and/or preauthorization, you are responsible for obtaining it. Failure to obtain the referral and/or preauthorization may result in a lower or no payment from your insurance company, and the balance will be your responsibility. Alternative payment arrangements or rescheduling of your appointment may be necessary if the necessary referral or preauthorization is not obtained.

Medicaid Patients

The Healing Sanctuary is both a Primary Care clinic and a specialty clinic. Therefore, if you are too be seen for primary care, we require you to have your PCP switched with Medicaid before we provide medical services to you. The Healing Sanctuary is a specialist for OB/GYN services, you can be referred to us through another PCP for these services. These are required and checked for every office visit you will have with us. You agree that your appointment will be canceled if you have not established us as your PCP or received the proper referral prior to your visit.

Medicare Patients

Please have a full understanding of your Medicare benefits, and what may be ***your*** responsibility. For some diagnoses, you may have to evaluate how well your treatment is working. To do that, the doctor requires certain diagnostic tests be performed. The doctor will tell you what those tests are and why they are necessary. Before your tests are performed, you may be asked to sign an Advanced Beneficiary Notice or "ABN." ***Why do we ask you to sign the ABN?*** We ask patients to sign an ABN whenever Medicare appears likely to deny payment for a specific service. Medicare requires we provide you a written notification when it is likely you will be responsible for the bill.

Self-Pay

Self-pay accounts ***must*** be paid in full at time of service unless prior arrangements have been made. You are self-pay if you are:

- A patient without insurance coverage
- A patient covered by insurance plans in which The Healing Sanctuary does not participate
- A patient without an insurance card on file with us

Fees

Phone Appointments

If you wish to speak to a provider by phone, it must be scheduled, and the phone consultation fee paid prior to speaking with the provider. We cannot bill your insurance for a phone consultation. Currently, insurance companies do not cover phone consultations.

Phone Visit Fee Scale		
	MD/DO	NP/PA
5-10 min	$75.00	$50.00
11-20 Min	$150.00	$100.00
21-30 Min	$225.00	$150.00

Email Conversations	
MD/DO	$100
NP/PA	$50.00

Missed Appointments

We require a 24 hour notice of appointment cancellation prior to your appointment.

- Your first office visit missed and not previously canceled will be charged a $25 fee, 2nd appointment is $50, and 3rd is $75
- Your first IV therapy or hyperbaric appointment not previously cancelled will be charged a $50 fee, 2nd appointment is $75, and 3rd is $100.
- If the IV bag is made before the cancellation, the charge will be full cost

The Healing Sanctuary sends appointment reminders via email and text messaging. If you wish to receive either of those, please let the front desk know. After your 2nd no show, a letter will be sent to you. After 3 No-Show's, we will send a Notice of Termination letter and dismiss you as a patient.

Returned Checks

Returned check fee is $25, payable by cash or credit card. This will be applied to your account in addition to the insufficient funds amount. Following a returned check, we may choose to place you on a cash only basis.

Estimated Costs

Estimated costs are not guaranteed since the services used to compute the quote can vary from services you actually receive due to treatment decisions, unforeseen complications, additional tests or services ordered by your physician, and variation in the clinical needs of each patient. Costs also will vary depending on your insurance coverage and deductible.

New Patient Office Visit: 250.00 to 430.00
Follow-Up Office Visit: 150.00 to 250.00
Prescription Refill: 75.00 to 150.00
Infusion Therapy: 50.00 to 350.00

Collections

If your account gets turned over to collections there will be a 33% collection fee added to your bill.

Payment

Prior to providing additional services to you, payment in full of total outstanding balances is required. All balances after 60 days will be charged an 18% finance charge.

Patient Payment Responsibility
We cannot offer services without expectation of payment. The patient or their legal representative is ultimately responsible for all charges and agrees to pay for all services received, whether covered or non-covered. "Non-covered" means that a service is not allowed for payment under your insurance contract. If you are unsure whether a service is covered by your plan, it is your responsibility to call your insurance company to determine what your schedule of benefits allows, if a deductible applies and your potential financial responsibility.

If your insurance company offers appeal procedures, we will not under any circumstances falsify or change a diagnosis or symptom to convince an insurer to "pay" for care that is not covered, nor do we delete or change the content in the record that may prevent services from being considered covered. This is insurance fraud.

Regardless of any personal arrangements that a patient might have outside of our office, if you are over 18 years of age and receiving treatment, you are ultimately responsible for payment of the service. Our office will not bill any other personal party.

Payment is expected at the time of your visit. We accept cash, debit or credit card. Payment will include any unmet deductible, coinsurance, co-payment amount, prior balance, or non-covered charges.

Payment Plan
Extended payment arrangements are available if needed. Please ask to speak with a billing coordinator to discuss a mutually agreeable payment plan. It is never our intention to cause hardship to our patients, only to provide them with the best care possible and the least amount of stress. A payment plan is not active until a Payment Plan Consent form has been signed.

Past Due Balances
Due to the high cost of rendering care and the low reimbursements by many insurers, we simply cannot afford to carry large account balances.

- Balances not paid within 60 days will be considered past due and will begin to incur 18% interest
- For past due accounts, a single phone call will be made to try to make payment arrangements
- Patients with accounts sent to collection face termination from the practice and will need to find another provider

Accounts sent to collection incur additional fees including but not limited to late fees, collection agency fees, interest and fines. The person financially responsible for the account will be responsible for all outstanding balances and collection costs.

Please direct questions regarding payment to:
The Healing Sanctuary Billing Department
(208) 497-0500

It has become increasingly expensive to collect fees rightfully due to the provider for services rendered in good faith to patients. Therefore, we have found it necessary to be very explicit in the financial policies of this practice. Non-payment by some affects the cost of healthcare to all of our patients. If you do not present a form of payment to meet your obligations to your insurance provider and to your healthcare provider, we cannot accept you as a patient or continue to schedule you for office visits.

Thank you for taking time to review our Financial Policy. This policy helps our office provide quality care to our valued patients. If you have any questions or need clarification of any of the above, please feel free to ask.

This financial policy is effective immediately as of the date signed below, and will replace any prior policies.

By signing The Healing Sanctuary's Financial Policy, I acknowledge that I have read, understand and agree to the above terms and conditions, and agree to ultimately accept sole responsibility for payment of my account in full.

Printed Name: _____

Signature: _____ Date: _____