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**FINANCIAL POLICY**

**Welcome to The Healing Sanctuary**: We appreciate your choice of The Healing Sanctuary for your healthcare needs. Our goal is to establish a positive and clear relationship with you, focusing on your health and financial responsibilities.

**Understanding Your Insurance:**

**Knowledge of Coverage:** It's crucial for you to know whether we are within your insurance network. If we aren't, you're responsible for the full payment at the time of service.

**Insurance Discrepancies:** If there's any confusion about coverage, you'll be considered a self-pay patient until it's resolved. As a courtesy, we'll file your initial insurance claim.

**Documentation Required:** Insurance card and a valid government photo ID are required during your visit as per the term of the insurance agreements.

**Co-pays and Co-Insurance:**

**Immediate Payment Required:** Co-payments and any past due balances must be paid at check-in.

**Payment Methods:** We accept cash, check, or credit cards. Note: Post-dated checks are not accepted.

**Deductibles:**

* If your insurance plan has a deductible, you must pay the full amount for services until it's met.
* Knowing your position within your deductible is your personal responsibility

**Claims and Insurance Response:**

* We allow 45 days for your insurance to respond to a claim. After that, any outstanding balance becomes your responsibility.

**Preventative (Annual) Exams:**

**Insurance Coverage:** Check with your insurance for coverage of any additional tests during these exams. The scope of a preventative visit is limited to insurance guidelines and your responsibility to know what’s included.

**Additional Charges:** If a medical decision is made during an exam, an extra office visit charge may apply.

**Referrals and Prior Authorization:**

* It's your responsibility to obtain any necessary referrals or prior authorizations. Failure to do so may result in you bearing the full cost.

**Medicaid and Medicare Patients:**

**Medicaid:** Ensure The Healing Sanctuary is your designated PCP or get a referral for specialist services prior to being seen or your appointment will be cancelled. If referral is not in place at the time of your visit

**Medicare:** Understand your Medicare benefits. Some services may not be covered. 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 Patients:**

* Payment is required in full at the time of service.

**Missed Appointments**

**Cancellation Notice**: We require a 24-hour notice to avoid cancellation fees.

**Fees**: Fees escalate from $25 to $75 for office visits and $50 to $100 for other services, based on the number of missed appointments.

**Dismissal**: If 3 or more visits have been no-showed, you will be subject to dismissal from the clinic, at the discretion of the healthcare provider.

**Legal Paperwork and Phone Appointments:**

* An office visit charge applies for filling out patient requested forms or paperwork.
* Phone appointments are not billable to insurance and require pre-payment.

**Estimated Costs and Cash Pricing:**

* Costs vary based on services and your insurance coverage.
* Estimated costs and/or quotes are not guaranteed

**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.

**Payment Responsibilities:**

* You or your legal representative are responsible for all charges, including those not covered by insurance.
* We cannot alter diagnoses or service records to influence insurance coverage.
* Payment is expected at the time of service, including any deductibles, co-payments, or non-covered charges.

**Payment Plans:**

* We offer payment arrangements for outstanding balances. A signed Payment Plan Consent form activates these plans.

**Accounts and Collections:**

* Accounts overdue by 90 days incur an 18% interest charge.
* Balances not resolved may lead to collection actions and termination of services.
* Accounts sent to collection incur additional fees including but not limited to late fees, collection agency fees, interest, and attorney fees. The person financially responsible for the account will be responsible for all outstanding balances and collection costs. Patient agrees to be responsible for any interest charges, court costs, and/or attorney fees if balance goes to collections.
* If for any reason the account should become delinquent, the responsible party agrees to pay up to a twenty percent (20%) collection fee of the unpaid balance; together with all legal fees, with or without suit, including reasonable attorney fees and costs.
* Upon being sent to collections, you are subject to dismissal from the clinic at the discretion of the healthcare provider

**Membership Agreement/Package Consent:**

All memberships, packages, and/or single treatments are non-transferrable, non-refundable, and expire after one year from date of purchase.

**Contact for Billing Queries:**

The Healing Sanctuary Billing Department: (208) 497-0500 or [billing@healingsanctuary.clinic](mailto:billing@healingsanctuary.clinic)

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 these terms and conditions, and agree to ultimately accept sole responsibility for payment of my account in full. I agree and it has been explained that the above cash pay services performed at The Healing Sanctuary are not generally considered accepted with respect to insurance coverage. Office visits or other medically necessary services may be billable to my insurance dependent upon my plan. I understand that this requires any payment in full for all services. I additionally understand that you may not attempt to bill my own insurance company for any of these services. I understand the scope and limitations of my insurance coverage and agree to pay all fees not covered by my insurance plan. I am fully responsible for all costs including labs, visits, or treatment procedures that are performed by the Healing Sanctuary, including costs denied by my insurance.

Printed Name:

Signature:                                                                                                                     Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_