FINANCIAL FORM

As part of our service to you, this Agreement outlines the responsibility of Aura Endocrinology (the "Practice") as it relates to your insurance coverage.

Payment Through Insurance

If you have medical insurance, we will submit claims on your behalf based on the treatment rendered by the Practice. It is your responsibility to know whether the Practice is considered an "in network" or "out of network" provider. The agreement you have with your insurance carrier will determine whether you will be held responsible for the payment of the treatment in full or a portion based on the coverage of your insurance. If you have any questions regarding your medical benefits, we recommend that you contact your insurance company directly.

At the time of your first visit, we will request a copy of your insurance card or print out from your insurance carrier that provides us with the following information: GROUP NAME, GROUP NUMBER AND ID #, AS WELL AS THE MAILING ADDRESS FOR MEDICAL CLAIMS. Without this information, the Practice will treat you as a private pay patient and it will be your responsibility to submit the insurance claim directly to your carrier.

Please note that we cannot waive the collection of your deductible or co-pay at the time of service.

We bill your insurance company as a courtesy. If insurance does not pay within 45 days, we reserve the right to request payment in full for services from you directly and let you collect the insurance funds that are due to you directly from your insurance company. Although this is a rare occurrence, you understand that you are ultimately responsible for all charges incurred in our office for medical treatment.

Out-of Network Provider By Insurance

As a patient receiving care from an out-of-network provider, you will always be held financially responsible for the full amount of all services, whether it is paid partly by insurance reimbursement and you pay the remaining balance or by you in full.

The Practice does not guarantee that your insurance company will pay for out-of-network treatment you receive from us. Regardless of whether your insurance company covers some or denies payment for all of the services provided by the Practice, you agree and understand that you will always be held solely responsible for paying the full amount owed for services provided by the Practice.
The Practice will not enter into a dispute with your insurance company over any claim, although we will provide necessary documentation your insurance company reasonably requests to sort out any confusion or questions that may arise. However, it is ultimately your responsibility to resolve any type of dispute over payments made or not made by your insurance company. Lastly, you understand that the Practice will not prepare or submit any insurance claims on your behalf for any treatment received from us.

Medicare

The Practice accepts Medicare and we are a participating provider. If you are covered by Medicare, please provide the Practice with all the necessary information related to your coverage at the time of your initial visit. You will be required to fill out an additional Medicare Financial Form at the time of your initial visit.

Cancellation

You understand that there is a 24-hour cancellation policy and are aware that you will be charged a cancellation fee of $150 for the first missed appointment and $200 cancellation fee for the second missed appointment if notice is not received within this time period. You understand that if there are more than 2 missed appointments, the Practice reserves the right to stop treatment, so long as it does not compromise your health in any way. For any appointments that are scheduled on Monday, you understand that any cancellations must be made on the previous Friday before 12pm. Additionally, you understand that clients who are more than 20 minutes late to an individual session or who exhibit excessive lateness may also incur a fee, at the sole discretion of the Practice. You understand that if you are late for any scheduled appointment, the Practice will provide services only during the allotted time of your appointment and your appointment will only last for the time remaining in your session accordingly. You further understand that payment is required at the time of service. Pursuant to the Practice policies, the fee will be charged directly to your credit card on file with the Practice and you will receive an electronic bill once payment has been completed.

Acknowledgement

I understand and acknowledge that I read, understand and agree to the above financial provisions related to medical treatment rendered by the Practice. I agree to pay all charges due (or to become due) to Aura Endocrinology. I understand and agree that regardless of my insurance status or absence of insurance coverage, I am ultimately fully responsible for the balance on the account for any and all medical services rendered at the Practice.

I represent that I am of sound mind and am legally competent to understand and complete this agreement. I hereby execute this consent form without coercion.

_____ _____

Patient Printed Name

_____ _____

Patient or Parent/Guardian Signature Date

_____

Parent/Guardian Printed Name

_____ _____

Witness Signature Date