**Purity Integrative Health & Wellness Center, PLLC**

**Financial Agreement – Updated 6/01/2021**

Thank you for choosing Purity Integrative Health & Wellness Center for your Naturopathic, Acupuncture, and Massage care. We know you have many choices in providers and we appreciate your business. We look forward to a relationship with mutual trust and an opportunity to help you obtain optimal health. As you know, payment for services is part of your care and part of our professional relationship. We have developed a financial agreement to make these obligations clear from the beginning.

**UNINSURED PATIENTS/TIME OF SERVIC/SELF-PAY**

Payment is due at time of service. Purity Health accepts checks and most major credit cards, we no longer accept cash. There is a discount for those paying for services in full at the time of service. If payment is not paid at the time of service, the price will revert to the uninsured price, and a $10 billing/late fee **per month** of non-payment will be assessed. Initials \_\_\_\_\_

**INSURANCE COVERAGE AND PAYMENTS**

We will gladly bill your insurance. It is **your responsibility to obtain and verify coverage**for the services provided at Purity prior to your scheduled appointment, we have a form we can provide that will show you the questions and codes to verify. **If you have a co-pay, this will be** **due at the time of service, should you choose not to pay at the time of service, a $10 fee will be added**. If your insurance denies coverage, you will become a self-pay patient (refer to section above). If they cover only a portion or your visit is subject to your deductible, it is your responsibility to pay the remaining balance (co-insurance and/or deductible). In the event that your insurance coverage has changed, it is **your responsibility to provide us with the new insurance company/card**, member ID number, and group number. If these are not received within the timeframe assigned by your insurance, you will be responsible for the full cost of the office visit that is not covered by your insurance company. At that time, we will provide you with a superbill and you may personally re-submit the bill to your insurance company for reimbursement. Initials \_\_\_\_\_

**TELE-MEDICINE (VIRTUAL VISITS)**

Due to the emergence of COVID-19, Virtual Visits/Tele-Medicine visits are allowed by insurances. These Virtual Visits/Tele-Medicine may be subject to a co-pay or other patient responsibility as determined by your insurance. Please verify your benefits for this type of service. Initials \_\_\_\_\_

**THIRD PARTY PAYORS**

If you are involved in an accident of any type, Purity will submit to third party payors such as PIP (Personal Injury Protection) for a Motor Vehicle Accident, or L&I (Labor & Industry)/WC (Worker’s Compensation) for an injury that occurred while at work. **It is your responsibility to provide ALL information, claim numbers, attorney information, etc., PRIOR to being seen**.  If you do not have this information, we will have you pay for the visit up front and YOU can request reimbursement from your insurance company, we will supply a superbill. ***If you do not have PIP coverage or your L&I/WC claim is denied, you will revert to an uninsured patient required to provide payment at the time of service.*** *Please note that issues or conditions that are outside the parameters of your PIP or L&I/WC coverage will need to be scheduled for a different visit on a different day*. Initials \_\_\_\_\_

**PHONE CONSULTATIONS**

Phone visits can be scheduled, by physician authorization only, and will be charged **a flat rate of $55 for each 1-15 minutes on the phone, $110 for 16-30 minutes, $165 for 30-45 minutes & $220 for 45-60 minutes**. **We will not bill your insurance for phone calls**. The fee will be waived if it is determined that an in-person office visit is required or if you are referred for emergency services. The fee will also be waived if it is a question limited to a current and documented treatment plan.

Initials \_\_\_\_\_

**EMAIL CORRESPONDENCE**

Due to HIPAA regulations, email consultations are not permitted. If there is an extenuating circumstance, we may make exceptions and these will be discussed ahead of time. There will be a $15 charge for **each email** received and responded to. You will be reminded of this charge prior to a response and an electronic acceptance of this charge will be required. Initials \_\_\_\_\_

**MISSED OR LATE CANCELLED APPOINTMENTS**

It is a professional courtesy to provide 48-hours’ notice if you cannot keep an appointment. There will be a $50 charge for your first appointment cancelled less than 48-hours in advance or missed all together, the second late cancellation or no-show will have a fee of $75, the third is $100, and the fourth visit will have a fee of $150 and a deposit of $50 required prior to scheduling your next appointment. If you are late to an appointment, please understand that you have a scheduled time, and this may result in your appointment being cut short to remain within the parameters of your scheduled appointment time. Initials \_\_\_\_\_

**RETURNED CHECKS**

There will be a $35 fee for returned checks in addition to the NSF fee from our bank. Please note that you will still be responsible for charges and asked to pay with a credit or debit card. Initials \_\_\_\_\_

**COLLECTIONS**

Should we be required to send your account to collections due to failure to pay, there will be a $50 collection fee.  Initials \_\_\_\_\_

**LABORATORY SERVICES**

As a courtesy, we have a LabCorp phlebotomist on-site, however, she is not an employee of Purity. If labs are ordered, you will be given a requisition to bring to the lab.  You are responsible for ensuring coverage of these labs and your financial obligation will be between you and the lab. Please direct financial questions regarding lab fees to the original lab you had your services performed. If you do not have coverage and our clinic offers you an uninsured patient discount, you are then in contract with Purity to pay your bill and this is due the SAME DAY you have your blood drawn.  If a test is ordered that initiated additional testing (called “reflex”), you will be billed the additional costs incurred.   Initials \_\_\_\_\_

**SUPPLEMENTS, HERBS AND SKINCARE**

Supplements and herbs are recommended by your provider for general health and most conditions. Patients may choose to purchase them from **Purity Integrative Health & Wellness Center, PLLC,**at recommended health food stores, or via our online partners, Emerson Ecologics (Wellevate), Xymogen, and Epionce. There is a 30-day return policy for **unopened** supplements purchased in our office.  Initials \_\_\_\_\_

**CREDIT CARD AUTHORIZATION & PAYMENT**

Due to changes in Healthcare Policy and increasing high-deductible Health Insurance plans, we have unfortunately experienced higher numbers of patients with unpaid medical bills. Therefore, we have implemented a new policy in which all patients are required to provide a credit card to be kept securely on file for future account balances. Please note that this does not change your existing rights with respect to the use of your card. You are still able or ask for investigation into your insurance company’s decision on a claim. Card numbers are stored securely off-site with our bank. Card numbers are not kept in our office. If you chose to not keep your card on file, there is a deposit required of $100 for **each visit**. This deposit will be used for any patient responsibility as per your insurance.

Co-pays will remain due at time of service as part of the contract between patient and insurance company. We will bill your insurance company(s) following your visit.  They are required to send us and you a copy of the Explanation of Benefits letter detailing what amount was covered/paid by your insurance, and what, if any, amount is owed by you, the patient.  The card on your account will be charged as payment in full for any remaining balance not paid by insurance. You will receive receipts via email as long as we are provided with your email address.  Transactions are run as credit, not debit, and are listed as “Purity Integrative Health and Wellness Center” or “Purity Health” on your statement. If you have any questions about this agreement, please contact our Billing office by phone at (425)338-2357 ext 4.  Initials \_\_\_\_\_

**PATIENT AUTHORIZATION AND UNDERSTANDING**

I have read and understand the financial policies of Purity Integrative Health & Wellness Center, PLLC.  I agree to abide by the terms of the financial agreement.  I request that payment of benefits be made to Purity Integrative Health & Wellness Center, PLLC and hereby authorize the release of any information necessary to determine the liability of payment and obtain reimbursement on any claim.  I further authorize the use of my signature below on all insurance submissions for services rendered or to be rendered.  I agree that a photocopy of this agreement shall be as valid as the original.  This authorization shall remain valid until revoked by me in writing and there has been a termination of services with Purity Integrative Health & Wellness Center, PLLC.

Thank you for your understanding and cooperation in our financial policies.  As stated before, payment for services is part of your treatment and part of our professional relationship.  This creates mutual respect and trust between physician and patient.  Should you default on any of the above financial terms and obligations, we will no longer be able to see you at the clinic.  We appreciated your support in helping us to continue to serve you and others.

**Patient’s Legal Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Name of Legal Guardian if applicable: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Patient’s or Legal Guardian’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_**