PHYSICIANS HolisticHealth Alliance

Dear Patient,

Regarding: Patient Financial Policy Changes

Thank you for choosing Physicians HolisticHealth Alliance, LLC and Uthman Cavallo, MD, LLC for your healthcare needs. We are committed to providing you with exceptional care, and to making our insurance billing processes as simple and efficient as possible.

Recent shifts in the healthcare industry have resulted in insurance companies increasingly transferring costs to our patients, you, the insured. This has driven our practice to adopt new financial policies to enable a more efficient operational process.

Effective January 1, 2020, Physicians HolisticHealth Alliance, LLC and Uthman Cavallo, MD, LLC will require all patients to keep an active credit card on file with us. Your credit card number will be securely stored.

Should you experience any difficulty paying your balance in full, we will be glad to discuss your account with you and set up a payment plan.

We understand that there are legitimate reasons that you may not have a credit card. If this is the case, you are welcome to leave a debit card, Health Savings Account, or a checking account for automatic withdrawals from your bank account.

Another important change is that we will no longer be mailing paper statements. Instead, we will send electronic statements via email.

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To understand the full extent of your financial responsibilities, ***please visit CaringForTheWholeYou.com/ Resources*** *and thoroughly review our 2020 Financial Policy.*

Please download the document, ***fill out the form, and return it to the office as soon as possible*** *(no later than December 20, 2019). If you have any trouble downloading the policy, contact our office at (574) 273-3880.*

In addition to the above, ***if you have an existing balance, please assist us in our transition by contacting our office at (574) 273-3880 to update your information as soon as possible.***

Thank you!

Your Partners in Health

53800 Generations Drive South Bend, IN 46635 P (574) 273- 3880 F (574) 271- 0918
CaringForTheWholeYou.com

Financial Policy

It is important that you understand your financial responsibilities for the services you receive. Your responsibilities are outlined in this document.

If you DO NOT have insurance, you are expected to pay at the time of service. For your convenience, we accept cash, personal checks, Visa, Master Card, and Discover.

While we take care of all billing for **cash-based** services in-office, please be advised that we outsource our **insurance** billing and partner with a company called Kareo. Should you have questions regarding your statement, **please contact Kareo** at the number listed on your statement.

Please check with your insurance plan to verify that your provider is in network with your insurance plan prior to any service being provided to you.

You must bring your insurance card with you to every visit and make us aware of any changes in coverage.

We also require a copy of your driver's license to confirm your identity.

You must notify us if you have and/or receive any **Medicare** or **Medicaid** benefits.

You are responsible for paying any known co-payment or deductible *at the time of service.*

Even if you have insurance, some services provided are not covered by your insurance plan or may be deemed medically unnecessary, experimental, non-covered and/or inclusive *and will be treated as not insured* and you are expected to pay at the time of service or at the time of scheduling.

Credit Card on File:

Effective January 1, 2020, Physicians HolisticHealth Alliance, LLC and Uthman Cavallo, MD, LLC will **require all patients keep an active credit card on file with us.** Your credit card number will be securely stored.

Should you experience any difficulty paying your balance in full, we will be glad to discuss your account with you and set up a payment plan.

We understand that there are legitimate reasons that you may not have a credit card. If this is the case, you are welcome to leave a debit card, Health Savings Account, or a checking account for automatic withdrawals from your bank account.

Charges to Your Credit Card on File:

We will send one statement to the email address you provide showing the balance you owe. We will charge your credit card no sooner than 10 business days from that statement date.

Circumstances when your card would be charged include but are not limited to

- missed or canceled sessions without 24-hour notice (a $50 fee will be charged),
- missed co-payments, deductible and co-insurance,
- any non-covered services and/or denial of services.

We will bill your insurance company; upon their determination they will send an **Explanation of Benefits (EOB)** to both you and our office showing the **amount of your total patient responsibility.**

You will typically receive the EOB before we do, **so if you disagree with the patient responsibility balance owed, it is your responsibility to contact your insurance carrier immediately.**

When we receive the EOB, we will send one statement via email showing the remaining balance you owe. We will charge this amount to your credit card on file no sooner than 10 business days from the statement date.

At that time, **any remaining balance owed by you will be charged to your credit card**.

We will only charge your credit card after your insurance informs us of patient responsibility.

If there is a problem with your bill/claim and you bring it to our attention AFTER your credit card payment processes, we will investigate the issue and refund the amount we owe you to the same card in a timely manner.

Electronic Statements:

Effective January 2020, we will no longer be sending paper statements via mail. Instead, we will send you electronic statements via email.

It is your responsibility to provide us with an accurate email address and to notify us of any changes to your preferred email address.

Declined Charges & Non-Sufficient Funds:

If the credit card we have on file for you changes, please notify our office **IMMEDIATELY** by phone or email.

It is not uncommon for people to change or cancel their credit cards for various reasons, including when a credit card expires. That is quite understandable, however, **if your credit card is denied for any reason,** we reserve the right to charge an additional $35 Declined Card Fee if we are not able to run a new credit card within 10 business days.

We will contact you or leave you a phone message on the phone number you provided for us, **asking you to give us a call with the new number right away.**

We will enter the new credit card number into your file, and *that will become your new card on-file,* subject to the same financial policy as the card you gave us in-person when you were in our office.

A $35 Non-Sufficient Funds (NSF) fee will be applied to your account for any returned checks.

Prior-Authorizations & Referrals:

We will obtain prior-authorizations if necessary. It is your responsibility to call your insurance and find out your benefits.

If your insurance company requires a physician referral, it is your responsibility to ensure that it has been obtained. If it has not, you will be asked to sign a waiver.

Delinquent Balances:

The PHA Business & Operations Team makes every effort to collect payment for balances before they reach the point of becoming delinquent.

Should your balance become delinquent, it will be referred to collections at the law office of Diamond & Diamond. At that point, you will no longer be able to receive services from PHA. We will transfer your records to a provider of your choice.

By Signing:

- I agree to accept responsibility for payment of fees submitted to my insurance carrier, and for any balance not covered by my insurance.
- I accept the responsibility to know my insurance plan's provisions.
- I waive the right to be informed of plan exclusions or service that may be considered medically unnecessary (as defined by my health plan), or non-covered services prior to receiving services.
- I am responsible for payment regardless of my insurance company's arbitrary determination of usual and customary rates.
- I am responsible to address specific coverage issues with my insurance company's member service department.
- I agree to all of Physicians HolisticHealth Alliance, LLC and Uthman Cavallo, MD, LLC's Financial Policy.
- I authorize Physicians HolisticHealth Alliance, LLC and Uthman Cavallo, MD, LLC to keep my signature and a valid credit/debit card number, Health Savings Account number, and/or checking account number securely on-file.
- I allow Physicians HolisticHealth Alliance, LLC and Uthman Cavallo, MD, LLC to automatically charge my credit card or any of the alternative payment methods listed above for any outstanding balances.
- In the event that my credit card expires or changes, I agree to immediately give Physicians HolisticHealth Alliance, LLC and Uthman Cavallo, MD, LLC a new, valid credit card or alternative payment method which I will allow to be keyed in over the phone in lieu of swiping in person.
- I agree that the new card or alternative payment method will still be subject to the financial policy listed here and may be used with the same authorization as the original card/alternative payment method which I presented in person.
- I understand that I am responsible for payment for all medical services provided to me by Physicians HolisticHealth Alliance, LLC and Uthman Cavallo, MD, LLC.
- I understand that my insurance may deny or delay payment for these services or only partially pay them, and I agree to allow Physicians HolisticHealth Alliance, LLC and Uthman Cavallo, MD, LLC to charge my credit card on file or alternative payment method on file for the balance if that happens.
- I understand that this form is valid until I cancel this authorization through written notice to Physicians HolisticHealth Alliance, LLC and Uthman Cavallo, MD, LLC.
- I agree that I am legally responsible for my account and all costs associated with the collection of my account. A collection fee, attorney fee or other fees that may incur to collect payment will be added to any outstanding balance.
- I authorize the practice, all associated physicians and all associated agencies, to gather, maintain and release any and all of my information that may be required for the processing of any and all claims for third party payers.
- I authorize Physicians HolisticHealth Alliance, LLC / Uthman Cavallo, MD, LLC to release information concerning illness or treatments to my insurance carrier, to submit fees for services rendered to my insurance for payment, and also direct payment to the Provider(s) who rendered medical services.

Financial Policy Signature Page

We will collect payment details separately for immediate secure storage.

Print Patient Name	Patient Signature	Date

Print Legal Guardian Name	Legal Guardian Signature	Date

Email for Electronic Statements

Please circle the payment method you wish to leave on file.

Credit Card Debit Card HSA Account Checking Account

For Staff Only

The above payment method has been received and securely stored. Date: _____

Updated 11/4/2019