AGAVE
SLEEP & WELLNESS
Better Sleep. Better Health.

FINANCIAL CONSENT TO PAYMENT POLICY

Thank you for choosing Agave Sleep & Wellness as your provider. We are committed to providing you with quality and affordable health care. This document outlines our policy for patients and insurance responsibility for services rendered.

Please read it and sign in the space provided. A copy will be provided to you upon request.

1. PAYMENT is required for all services at the time they are rendered. All applicable co-payments and/or deductibles will be collected at time of service. We accept checks and credit cards. **We are now collecting at time of checkout based on the contracted rate with your insurance.**

A fee of $25 will be assessed for return checks.

2. CREDIT CARD ON FILE* We require a valid credit or debit card to be kept on file at all times. This is to expedite payment or refund to you in case of insurance coverage and benefit discrepancies from time of visit to time of insurance claim adjustment. You will receive a statement which may be paid online. If we do not receive a timely payment, your card will be charged or refunded in the amount listed. You will receive a receipt of payment or credit once processed. Full policy can be found online at www.agavesleepandwellness.com

3. INSURANCE. **Your insurance coverage is a contract between you and your insurance company.** Agave Sleep & Wellness participates in most insurance plans, including Medicare. If you are insured by a plan we do business with, but do not have an up-to-date insurance card, payment in full for each visit is required if your coverage is not able to be verified. If you are not insured by a plan we do business with, payment in full is expected at each visit. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions regarding your coverage and benefits.

4. PROOF OF INSURANCE. All patients must complete our patient information form before seeing the provider. We must obtain a copy of your photo ID and current valid insurance card to provide proof of insurance. Failure to provide us with the correct insurance information in a timely manner will leave you with full responsibility for the claim.

5. NON-COVERED SERVICES. Please be aware that some or all services you receive may be non-covered by Medicare or other insurers. Payment in full for these services will be required at your visit.

6. CLAIMS SUBMISSION. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may require you to supply specific information directly. It is your responsibility to comply with their request. Your insurance benefit is a contract between you and your insurance company.

7. REFERRAL. If your insurance requires a referral from your primary care physician (PCP), it is your responsibility to obtain the referral prior to your appointment.

8. NO INSURANCE. If you have no insurance, you will be required to pay for your office visit and procedures completed in full at check out.

9. COVERAGE CHANGES. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

10. NON-PAYMENT. If there is no payment for services and your credit card on file is invalid and your account becomes overdue by 120 days, we may refer your account to a collection agency.

11. CREDIT BALANCES. For any accounts with credit balances, we will refund amounts due back to you to your credit card used for initial payment or via a check once your insurance claim is processed and your patient responsibility amounts are satisfied.

RESPONSIBLE PARTY SIGNATURE:_____

NAME OF PATIENT:_____

NAME OF RESPONSIBLE PARTY:_____

(if different from patient)