Bernacki Wellness Center

Financial Policy

Thank you for choosing us as your healthcare provider. Please understand that payment of your bill is considered part of your treatment. We require that you read and sign the Financial Policy prior to any treatment.

____FULL PAYMENT OF AMOUNT DUE, INCLUDING COPAYS AND CO-INSURANCE, IS TO BE PAID AT THE TIME OF THE VISIT.

____WE ACCEPT CASH, CHECKS, VISA, MASTERCARD, DISCOVER, AMERICAN EXPRESS.

____We do accept assignment of many insurances. However, your insurance may not cover the total expense. The balance is your responsibility.
____We cannot bill your insurance company unless *you give us your correct information.*
____Your policy is a contract between you and your insurance company. We are not a party to that contract.
____If your insurance has not paid us in 45 days, the balance will automatically be transferred to your patient account.

____Please be aware that some, and perhaps all of the services provided may not be covered and not considered reasonable and necessary under Medicare guidelines or other medical insurance.

Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area.

MINOR PATIENTS

- **The adult, accompanying a minor, and the parents (or guardian) are responsible for full payment. In divorce cases the parent with whom the child resides is responsible for payment of the bill. For unaccompanied minors, non-emergent treatment will be denied unless charges have been pre-authorized to an approved credit card or payment by cash or check at the time of the visit has been verified.**

INTEREST

- **We reserve the right to charge interest in the amount of 2% as provided by state law.**

Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.
I understand and agree to this financial policy

*X*____ *Date*______________
(Signature of patient or responsible party)