

# *Close to You Incorporated*

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## ***Financial Policy***

Thank you for choosing us as a Health services provider. We are committed to your successful treatment. The following is a statement of our financial policy, which we require that you read and sign prior to treatment. Anytime you have questions regarding any treatment fee or service please discuss them with us promptly and frankly. We will make every effort to avoid misunderstanding.

### **Regarding Insurance:**

As a courtesy to you, we will bill your insurance carrier for you, Effective January 1, 2010, any unpaid balances 60 days or older will be assessed a service charge equaling 1% of the outstanding balance. Outstanding accounts will be submitted to small claims court if prior arrangements to pay have not been made or if you fail to make your agreed upon monthly payment.

Please be aware some and perhaps all of the services provided may be considered “non-covered” services and are not considered reasonable or necessary under some medical insurance policies. If you are unable to pay in full, it is your responsibility to contact us and set up an agreeable payment plan. Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. Returned check fee is \$40.00. If you are notified by our office that you have a returned check you will have until the close of business the next day to present our office with cash or cashier’s check plus the returned check fee. Person’s who write bad checks will be prosecuted to the greatest extent that Texas law allows up to and including imprisonment. Patients acknowledge that they are responsible for any and all collections costs and/or attorney fees.

### **Usual and customary rates:**

Our practice is committed to providing the best treatment possible for patients and we charge what is usual and customary for the area. You are responsible for payment in full regardless of any insurance company’s arbitrary determination of the usual and customary rates.

## Medicare:

We take Medicare assignment, and will bill Medicare and your secondary insurance for you.

## Co-Pay and Deductible:

Co-Pays and Deductibles are required to be paid at the time of service. If the amount is different at the time of payment by the insurance billing the difference will be refunded back to the patient or additional amounts will be billed to the patient.

## Insurance Gap exceptions:

Close to You works hard to see that insurance coverage for services rendered takes place both in and out of network. Since our service is unique it is sometimes acceptable to be seen as an in-network provider even with insurance companies we are not providers with. The estimated time for a network exception can be up to 10 to 15 days. We give the patient the option to wait for that period before services are rendered or to pay 50% of the total billed services to start service immediately. If the Gap exception is approved the amount will be refunded minus in network co-pays and deductibles.

## Upgrade policies:

Your insurance company will pay for only the basic product. If you choose to upgrade your product payment for the difference in cost will be collected at the time of sale. The upgrade cost plus co-pays and deductibles will be collected. If you choose not to look at products that would be considered an upgrade please ask your fitter to show you only what is covered under insurance and Medicare pricing.

Thank you for understanding our financial policy. If you should have questions or problems, please let us know and we will be happy to assist you in every way possible.

- I have read the financial policy (above). I understand and agree to this.
- I hereby authorize my insurance benefits from both primary and secondary carriers to be billed on my behalf and to be paid directly to Close to You Inc., realizing I am responsible to pay any and all charges that exceed or that is not covered by insurance. I authorize the release of pertinent medical information to the insurance company or worker's compensation carriers.

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Patient Signature or Responsible Party

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Date

# Written Acknowledgement of Receipt

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## Supplier Standards and Notice of Privacy

I \_\_\_\_\_, acknowledge that I have received the written Notice of Privacy practices and a copy of the Supplier standards from Close to You Inc.

\_\_\_\_\_  
Patient or Personal Representative Signature                      Date

- The patient's condition prohibits the individual from signing an acknowledgement at this time. It will be obtained as reasonably practicable after patients condition improves.
- Acknowledgement was unable to be obtained.  
Reason: \_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Employee Signature                      Date

### Disclosure of Private Patient Information

The following person(s) may receive private patient information without my written consent:

1. \_\_\_\_\_  
Name                      Relationship

2. \_\_\_\_\_  
Name                      Relationship