CHART # _____

COMPREHENSIVE
Wellness Center

Your Path To Maturing Gracefully

OFFICE POLICIES

_____ Our office will schedule appointments as common courtesy for clients and in consideration of your time. We require a minimum 24 hours (or the Friday before a Monday appointment) notice of cancellation as a courtesy to other clients seeking services. A fee of $25 will be charged for non-cancelled and missed appointments. A pattern of non-cancelled or missed appointments may result in discharge from the practice.

_____ Our practice charges for additional paperwork outside of the completion of the medical record. The following fees apply and are subject to change without notice: FMLA and other forms range from $35 - $75. Additional fees may apply at the discretion of the practice and upon notification to you.

_____ The medical chart is the property of the practice. However, copies of your medical information are available upon request. The practice charges a fee for a copy of the record. This fee is available upon request. There is no charge to send records to another provider.

_____ Insurance companies do not pay all fees and may exclude certain services from coverage. It is your responsibility to understand your insurance plan. All co-payments, deductibles, co-insurance, or non-covered service are to be paid in a timely fashion and prior to further services. If requested, and as a condition of service, you agree to sign an "advance beneficiary notice" if we determine or question your insurance coverage. You accept responsibility for all such expenses even if your insurance company is billed as a courtesy.

_____ Some insurance plans may indicate that our fees are above "usual and customary". As a result, your plan may reduce our fee to an "allowed amount" before calculation of payment. This practice does not recognize a specific carrier's use of these terms. As such, unless we have specifically contracted a priced reduction with your insurance carrier, it is expected that you will be liable for our full fees.

_____ You agree that if your insurance company takes more than 60 days to respond to your insurance claim that we shall consider your service your financial responsibility and it will be your responsibility to seek reimbursement form your insurance company.

_____ Although our office is happy to treat your medical conditions, if the cause is related to an auto or work – related accident you may be required to pay the full fees at the time of your visit unless accommodations have been made.

SAINT ADEOGBA MD
9712 WEST MARKHAM LITTLE ROCK, AR 72205
(501) 954-8800

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_____ Our billing company sends client statements each month. Payments are due upon receipt of statement. You understand that if we participate with your insurance company the sending of a statement may be delayed until your insurance responds to a claim for services. Such delays can take months. You understand that such delays do not alter our policy of a client's financial responsibility and you will be liable for all service fees. A late fee may be charged for client balances due that are more than 60 days old.

_____ Accounts more than 90 days old are subject to transfer to an outside collection agency. These agencies charge fees. You agree to be liable for all such fees.

_____ The practice reserves the right to discharge a client for any reason. Please note that discharge may occur due to failure to meet your obligations under this document. In addition, because of care quality considerations, the practice may discharge you for failure to comply with treatment plan(s) as outlined by your provider.

_____ If applicable, our office will submit insurance claims. You agree to allow our practice to "accept assignments" of benefits and receive payment directly from your insurance company. In the event your insurance sends payment for a claim from our office to you directly, you agree to endorse the payment to our practice in fulfillment of any amounts due within 10 days of postmark.

_____ I consent for Dr. Saint Adeogba and staff to treat me for my medical condition. I understand and have read the Office Policies for Comprehensive Wellness Center and as part of treatment, payment, or healthcare operation it may be necessary to disclose and release my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

_____ I hereby accept responsibility for any service(s) provided to me that is not covered by my insurance. I also accept responsibility for fees that exceed the payment made with my insurance company. I have also read the HIPAA practice Act.

_____ _____
Client Name Date

_____
Client Signature

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