KRISTIE ROSSER

Optimal Wellness

KayRoss Education, INC.

FINANCIAL POLICY

Our office needs your **understanding** of **your financial responsibility to our office** for the services we provide to you.
We reserve the right to change our policies as deemed necessary.

Our office **does not accept insurance**, Medicare, or Medicaid. A hand-written 1500 HCFA form is available at appointment upon request.
We **do not accept personal checks, American Express card, Discover card, or Business spending cards**.
We accept health savings/flex spending cards. Debit card or cash payments are ***preferred.***

We require full payment at time of service. All past-due balance is due in full at time of service before provider is seen. **We do not carry delinquent balances beyond 30 days**. Future appointments, prescription refills, and other office services will not be authorized until balance is paid in full. A **$15 billing fee** is added every 30 days to each monthly, unpaid-balance statement. Standard interest accrues.

Our **financial relationship is with you** and all charges are **your responsibility**. If insurance is used for testing procedures or blood work, it is your responsibility to understand facility/lab preference, coverage, and limitations. Testing/labs ordered by our office are diagnostic, and generally **NOT be coded as preventive**.

Purchases made in the office are non-refundable. Flex-Spending or Health-Saving Account cards are acceptable forms of payment.

There will be standard office **charges for all additional paperwork** requested, including but not limited to: **retrieval and copy records fee**, **postal fee** for items mailed out from our office, **lost-requisition fee, and additional paperwork fee requiring Provider signature**.

If we have not been successful in receiving full payment for services, any unpaid-balance owed ***45 days*** past date of service is **considered *delinquent*** and will be turned over to a collection agency. Once turned over to a collection agency, future appointments, prescription refills, etc. will not be authorized. A patient dismissal letter will be mailed excusing you from our office.

In respect of our extensive priority list, we require at minimum **48 hour/2-business day notice** for all appointment changes and cancellations.
All appointments must be held with full payment. This amount will be credited to office visit fee upon arrival of appointment or with an appropriate appointment cancellation per our policy.

If the 48-hour/2-business day cancellation courtesy is not provided, **50% of the visit fee will be held and applied towards the "no call/no show/late cancellation" charge**. Future visits will not be authorized after two "no call/no show/late cancellation" events.

Full program fee is due before the first program visit. Program patients must give **48 hour/2-business day notice** for all appointment changes or the program visit will be forfeit from the program scheduled visits.

By signing below, I agree to pay all amount(s) owed within 30 days of service. Regardless of insurance coverage, it is and shall remain my responsibility to pay all amounts owing as set forth herein. I agree to pay an additional 40% collection fee of principal amount(s) owing as allowed by Utah Code Annotated sec.12-1-11, with or without suit, attorney fees and court costs. I agree that interest will accrue on all past-due amount(s) at the rate of 18% per annum (1.5% per month) until paid in full.

The terms of this document shall apply to all amount(s) incurred by me or by any individual for whom I have legal responsibility whether such amount(s) are incurred today or after today.

Patient Signature______________________________Date_____________ Witness Initial _____ Date ______________

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