Service and Financial Policy

Thank you for choosing California Neurohealth, as your health care provider. This office is firmly committed to your successful treatment. Our staff will work diligently to make sure paperwork is filed accurately and promptly. In turn, we expect you to communicate clearly with your practitioners at California Neurohealth and cooperate fully in the payment of your bill. The following is a statement of our Financial Policy, which we require you read and sign prior to any treatment.

In order to provide you with the highest quality service while keeping our billing costs low and our time on the phone with insurance companies to a minimum, we offer paperless patient billing through “The Easy Pay Plan”. We simply maintain your credit card number on file to satisfy all costs and balances for service. This information will be kept strictly confidential, in our electronic medical records system, and will only be available to your practitioners. Your number will only be used with your authorization for services rendered.

This office can accept assignment from insurance and will expect payment of your full financial obligation at each visit. WE ACCEPT VISA, MASTERCARD, AMERICAN EXPRESS, HSA or HRA, PERSONAL CHECKS AND CASH for these payments.
We will bill your insurance as a courtesy to you. Your insurance will then pay you directly. Your insurance policy is, however a contract between you and your insurance company. Under that contract, you are responsible for all co-pays, deductibles and uncovered services, etc., just as this clinic is legally responsible for collecting these payments from all patients.

Please understand that insurance reimbursement can be a long and difficult process. In fact, many insurers will routinely stall, deny and reduce payments. Keep an open communication with your insurance regarding your reimbursements and contact them with in the 30 days, if you have not received your payments.

I hereby assign my insurance benefits to be paid directly to the provider of service. I understand that I am financially responsible for any non-covered services. I also authorize the provider to release any information required to process any claims.

Printed Name_____
Signature_____Date_____

Your responsibilities:

1. You are responsible for sending a copy of any explanation of benefits (EOBs) received from your health insurance to California Neurohealth, via email with in two weeks of receiving the EOB. This will give us time to appeal or re-send any claims applicable; as well as help us understand what your insurance reimbursements are .

2. You are accountable for any change in insurance coverage. In this same regard you agree to promptly provide the insurance company with any and all information it needs to adequately process your claim.

3. You will notify the office immediately of any change in your mailing address or telephone number

4. You are advised that in addition to charges for medical services, there will be:

a) Charge of $25 for all returned checks
b) Charge of $20 for each form (disability, credit deferrals, etc.) presented by the patient for completion by the physician or staff. This charge shall be paid in advance.
c) Minimum charge of $350 for any requested dictated report (for legal or insurance purposes), payable in advance.

5. All payments are due at the time of service. This medical office reserves the right to charge interest in the amount of 15% for unpaid balances, beginning 60 days after the date of treatment.

6. I understand that my insurance policy is a contract between me and my insurance company. Under that contract, I am responsible for all co-pays, deductibles and uncovered services and may be reimbursed directly by them.

7. I have read this Financial Policy. I understand and agree with its terms and obligations.

Patient signature _____Date _____

I,_____, authorize, to charge my credit card for all payments due including co-pays, deductible, all covered and non-covered charges. This also covers charges billed but not paid including co-pays, deductible and all non-covered charges. This also covers charges billed but not paid by insurance within 60 days should Elham Khodabandeloo L.Ac., Christopher DeMartin DC, DACNB, and California Neurohealth choose to accept assignment. I understand that, as a courtesy to me, my primary insurance company will be billed by Elham Khodabandleoo L.Ac., Christopher DeMartini DC, DACNB, and California Neurohealth, but that payment for the above charges is my responsibility, based on my contract with my insurance company and my agreement herein with the office of Elham Khodabandeloo L.Ac., Christopher DeMartini DC, DACNB, and California Neurohealth.
Automatic payment will be transferred to my credit card per visit.

Please choose one of the following for communications:

___I give my permission for California Neurohealth practitioner and staff to contact me via text, fax and email.
Contact#:_____
Fax #: _____
email:_____

___I would like California Neurohealth to only contact me via “Patient Ally” a secure patient portal requested and activated by me.

I understand that this form is valid unless I cancel the authorization by written notice to California Neurohealth at 1411 Marsh st suite 106, San Luis Obispo, CA 93401, once my account has been paid.

_____ _____
Cardholder Signature Date

Patient name (s):_____
Cardholder Name:_____
Cardholder Address:_____
(Please Circle One) Visa / Mastercard / American Express / HSA / HRA

Credit Card #:_____
Expiration date:_____Code:_____