New Heights
Health & Wellness

Financial Policy & Consent for Payment

Patient Name: _____ **DOB:** _____

Our Commitment to You

We are committed to providing you with quality care. To avoid misunderstandings, this document explains our financial policies. Please review carefully and sign below.

Insurance

- We will bill your insurance company as a courtesy if you provide complete and accurate insurance information.
- Your insurance policy is a contract between you and your insurance company. **You are ultimately responsible for payment of all charges.**
- You are responsible for knowing your insurance benefits, including coverage, co-pays, deductibles, and prior authorization requirements.

Patient Responsibility

- **Co-pays, deductibles, and coinsurance** are due at the time of service.
- If your insurance denies or does not cover a service, you are responsible for the balance.
- **Non-covered services** (including certain wellness, care management, or telehealth visits) must be paid out-of-pocket.
- If you do not have insurance, **payment in full** is expected at the time of service unless prior arrangements are made.

Chronic Care Management (CCM) & Transitional Care Management (TCM)

- Medicare and some commercial insurers cover CCM/TCM services.
- Standard Part B **coinsurance and deductibles apply**.
- Only **one provider may bill CCM or TCM** per period (per month or per discharge).

- By enrolling, you agree to be responsible for any cost-sharing not covered by insurance.

Payment Methods

We accept: ☐ Cash ☐ Credit/Debit Card ☐ HSA/FSA ☐ Check
Returned checks may incur a **$35 service fee**.

Balances & Collections

- Balances not paid within **30 days** will receive a statement.
- Accounts over **90 days past due** may be sent to collections.
- Collection costs, including legal fees, may be added to your balance.

Missed Appointments

- Please provide **24-hour notice** if you must cancel or reschedule.
- Missed appointments without notice may result in a **$35 no-show fee** (not billed to insurance).

Consent for Payment & Release of Information

I authorize **New Heights Health and Wellness** to:

- Bill my insurance for services rendered.
- Release necessary medical information to process claims.
- Receive payment of benefits directly from my insurance company.
- Hold me financially responsible for all charges not covered by insurance.

Patient/Responsible Party Signature: _____

Print Name: _____

Date: _____

Staff Witness: _____