Holistic Healing Center Office Policies

Thank you for choosing Deborah R. Bernstein MD and the Holistic Healing Center to support you in attaining optimal health and well-being. We are committed to providing you with personalized holistic health care. Because some of our patients have had questions regarding patient and insurance responsibility for services rendered, we developed these office policies. Please read them, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Insurance. We currently participate in many insurance plans, including Medicare. If you are insured by a plan with whom we don't do business or are out of network, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. **Knowing your insurance benefits is your responsibility**. Please contact your insurance company with any questions you may have regarding your coverage. **Medicare patients, please make sure to contact Medicare to give them your supplemental insurance information.**

2. Proof of insurance. All patients must complete our patient information form before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim.

3. Coverage changes. If your insurance changes, **please notify us before your next visit** so we can make the appropriate changes to help you receive your maximum benefits. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

4. Co-payments, co-insurance and deductibles. All co-payments must be paid at the time of service. If your insurance benefit has a deductible and you have not yet met the deductible at the time of your visit and/or you have to pay co-insurance, **you will be responsible for paying for the services provided as per your insurance contract. We will bill you for this when we receive the explanation of benefits** from your carrier. This arrangement is part of your contract with your insurance company.

5. Claims submission. We will submit your in-network claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. **Please be aware that the balance of your claim is your responsibility whether or not your insurance company pays your claim.** Your insurance benefit is a contract between you and your insurance company; we are not party to that contract.

6. Non-covered services.

- **While you are at the office**: Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. **You must pay for these services in full at the time of the visit**. Please refer to the Cash Payment Agreement for more information.

- **Phone Consults.** You may schedule a phone consultation to discuss medical issues with Dr. Bernstein. Since insurance only covers face-to-face encounters, you will be billed for the phone consult at the rate of $4 per minute. There will be no charge for a short question that takes under two minutes.

- **Administrative Services.** The following services have associated fees: $10 for writing and calling in a prescription between visits; a fee for full chart copies to be mailed or faxed; a $10 fee for reviewing and administering out-of-network lab forms; and a $20 fee for a returned check.

8. Medical Nutrition Therapy. Our Integrative Functional Nutritionist, Audrey Fleck, is in network with many insurance carriers. However, each carrier and plan has different benefits and eligibility requirements for coverage of Nutritional Counseling. If you're interested, we will check your insurance benefits for Medical Nutrition Therapy. On occasion, a carrier will tell us that a patient has coverage and then later deny the claim. If your carrier denies the claim, we will do our best to collect, but you are still responsible to pay for the services provided.

9. Prior Notification Policy for Changing Appointments. If you need to reschedule, please call to change your appointment as far in advance as possible so another patient waiting for an appointment may use that time. We require **at least two business days' prior notice to change an appointment**. You will receive a reminder email four days before your appointment. **Please call us at that time to confirm**. If you don't provide the required two business days' notice we have the right to fill your appointment with another patient from our waiting list.

There will be a charge equal to the fee for service rate for your visit unless the appointment time is able to be filled. If another patient is able to fill the spot, a $25 fee will be charged for the administrative time required to fill the appointment. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Thank you for reading our office policies. Please let us know if you have any questions or concerns.

The office number is 215-794-7880. Please use this number to leave messages, request information or to schedule or reschedule appointments.

I have read and understand the office policies and agree to abide by their guidelines.

I authorize Deborah R Bernstein MD LLC to release any medical information necessary to process my insurance claims.

I authorize and request payment of medical benefits directly to Deborah R Bernstein MD LLC.

I agree that this authorization will cover all medical services rendered until such authorization is revoked by me.

I agree to pay all charges not covered by my insurance carrier(s). These charges include, but are not limited to deductible, co-insurance and co-payments of my insurance policy.

_____ _____

Signature of patient or responsible party **Date**