DR. HILARY COSTELLO
HOLISTIC DERMATOLOGY ✵ NATUROPATHIC MEDICINE ✵ SKIN SURGERY

Financial Policies

1) Please take time to read and sign this financial responsibility statement before your first visit. Thank you.

2) INSURANCE BILLING POLICY:
We are in-network providers for the following insurance companies: Aetna, Cigna, First Choice, Moda, Pacific Source, United Health Care, Blue Cross Blue Shield. We do not offer billing services for all other insurance companies. If requested, we will provide you with the proper paperwork to submit on your own for reimbursement.

Your insurance may pay only a portion of the charge for your treatment. You are responsible to pay for any balance on your account. We will bill you for the remainder once we have received the payment and explanation of benefits from your insurance.

Please confirm your insurance coverage with the frond desk staff before coming in for your first appointment.

Due to the variability of insurance coverage in general and for Naturopathic coverage in particular, we strongly suggest you call your insurance provider to determine which services might be covered in your policy, and to what extent. We will happily provide you with an "**Insurance Verification Form**" to help you determine the extent of your specific coverage plan.

Cosmetic or other aesthetic procedures generally cannot be billed to insurance. Your doctor will help determine if insurance reimbursement is possible on an individual basis.

3) GENERAL INFORMATION:
If we are not billing your insurance for your appointment or procedure, then payment for all services will be due at the time of service. We accept cash, checks, Visa and MasterCard. Returned checks will be subject to a $35.00 non-sufficient funds fee.

In addition, all supplements, labs (except those billed directly to patient or insurance), and uninsured procedures (explained by your doctor) require payment at the time of service.

Your doctor may prescribe supplements or medication, which may be purchased at our office or elsewhere. Most insurance companies do not cover the majority of products we prescribe and dispense. However, your doctor can provide you with an insurance reimbursement form for you to submit directly to your insurance company.

If we are billing your insurance, then you are responsible for your co-pay or co-insurance at the time of service. If your insurance has a deductible, you must pay the full amount at the time of service until the deductible is met.

4) CANCELLATIONS AND MISSED APPOINTMENT FEES:

We require at least 24 hours notice to change or cancel return visits for established patients. The fee for missed appointments and late cancellations is $55.00. If you miss your first appointment without giving 24 hours notice, you will be asked to put down a deposit of $100.00 to reschedule; this deposit will apply towards your first visit.

5) COMMUNICATION FEES:

In order for us to provide the highest quality health care and privacy possible, we generally refrain from using electronic methods (such as email, Skype, FaceTime, etc) to provide medical care. However, we are willing provide these services if circumstances prevent an office visit. These visits must be pre-approved and an appointment must be made as usual. A patient with an electronic visit appointment of 30 minutes will be charged a visit fee of $120.00, plus any additional charges. Phone calls and emails that require more than 10 minutes of attention from your physician will incur a fee. Your doctor will notify you of the need for a charge, so you can determine whether you would like to address the issue and pay the fee, or schedule an appointment. Phone and email charges are not billable to insurance.

ACKNOWLEDGMENT:

I have read this financial policy statement and understand its terms. I understand that delinquent accounts may be assigned to a credit reporting collections service. If it becomes necessary to pursue collections of any amount owed, I agree to pay for all costs and expenses, including reasonable attorney fees. There will be a $50.00 fee added to any accounts referred to collections. I hereby authorize Luca Holistic Medicine to release any information necessary to secure payment.

Print Patient's Name: _____ D.O.B. _____

Responsible Party: _____ Relationship to Patient: _____

Signature of Responsible Party:_____ Date:_____

Social Security Number of Responsible Party: _____-_____-_____