Patient Financial/Privacy Policy and Disclaimer

ASTRA
PERFORMANCE HEALTH

Insurance Verification

Insurance verification is not a guarantee of payment. Verification is only a quote of patient benefits. Insurance companies review charges individually and make payment accordingly.
Charges not covered by insurance are the patient's responsibility and due within 30 days of billing.

Deductible Payments

It is our policy to collect at time of service. Once we receive an "Explanation of Benefits" report from the patient's insurance company, we will bill or credit the account for the remaining balance. Reimbursement checks can be issued upon request.

Collection of Patient Balance

Co-payments and Co-insurance is the patient's responsibility and will be **collected at the time of service**.

If an "Explanation of Benefits" or EOB shows the patient has an outstanding responsibility for any reason, the patient will receive a bill outlining the outstanding charges. **Payment is due within 30 days** of receipt of the bill.

In the event a bill is disputed, you must notify use within 30 days. If you do not notify us within that time, the bill will be presumed valid and due. All balances remaining unpaid after 30 days will accrue **interest at the rate of 18% per annum**. In the event any further action is necessary to collect an unpaid bill, you will be responsible for all attorney's fees and court costs incurred by us.

All balances remaining **unpaid after 30 days may be reported to a credit bureau** and affect your credit rating.

Returned Checks

It is our policy to collect **$25.00 for checks that are returned to us**. This is to cover any fees that apply from the transaction.

Appointments

If you are unable to keep an appointment, as a courtesy to other patients and our staff, please give us **24 hours notice**.

Financial Policy Questions

We are happy to address questions regarding your account at any time. Please direct accounting questions to our billing administrator.

HIPAA Privacy Policy

Attached to the patient information packet at the back of these forms is the HIPAA Notice of Privacy Practices Policy for you.

By signing below, the patient acknowledges that he/she has received the HIPAA Privacy Policy and that he/she understands and will comply with our financial policies.

I authorize this office to allow family and friends looking for me to be given information as to my arrival or departure of the premises, and or leave a message for me if I have not arrived or am in with the doctor.

Designation of Authorized Representative

I do hereby designate Astra Performance Health to the full extent permissible under the Employee Retirement income Security Act of 1974 ("ERISA") and as provided in **29 CFR 2560-503-1(b)4** to otherwise act on my behalf to pursue claims and exercise all rights connected with my employee health care benefit plan, with respect to any medical or other health care expense(s) incurred as a result of the services I receive from Astra Performance Health. These rights include the right to act on my behalf with respect to initial determinations of claims, to pursue appeals of benefit determinations under the plan, to obtain records, and to claim on my behalf such medical or other health care service benefits, insurance or health care benefit plan reimbursement and to pursue any other applicable remedies.

IRREVOCABLE Power of Attorney

I do hereby authorize Astra Performance Health to act on my behalf to pursue claims and exercise all rights in order to collect insurance payments with respect to any medical or other health care expense(s) incurred as a result of the services I receive from Astra Performance Health.

Patient's Signature: _____ Date: _____