Well Life
FAMILY MEDICINE

OFFICE FINANCIAL POLICY
HEALTH INSURANCE

We would like to welcome you to our office and assure you that you will be receiving the very best care available for your condition. Due to the vast changes that are taking place in the insurance industry, the financial aspect of medical care is becoming much more complex. For this reason we feel a need to familiarize you with the financial policy of this office and explain how your medical bills will be handled. This form is designed to communicate as clearly as possible **your coverage** and our office policy so that there are no misunderstandings.

1. We are filing with your insurance company as a service to you. This is done weekly.
2. You are responsible for all charges incurred whether insurance pays or not.
3. If your insurance company is not able to confirm that your deductible has been met we will collect 100% of the charges until we are notified differently by them.
4. We try to verify benefits at the time of your initial visit. **Until benefits are verified we will collect 100%** of the charges and then refund any credit balance after we receive your insurance payment.
5. **Once your benefits are verified** we make every effort to collect **only your portion.** However, sometimes we or your insurance company make mistakes. **Please read your Explanation of Benefits (EOB's) from your insurance company carefully** -- call us if there is a problem. We do not want to jeopardize our relationship with you as a patient. Our goal is to have you and your family as life-long patients.
6. Verification of benefits from your insurance company is **not a guarantee of payment**. If for any reason your insurance company doesn't pay a portion of the bill (e.g., your deductible had not been met; non-covered services) – these charges immediately become due and payable by you. Our office will **NOT** enter into a dispute with your insurance company over your claim. This is your responsibility and obligation.
7. I authorize the release of any medical information necessary to process my claims. I also authorize payment of medical benefits to Dr. Ehle for services rendered.

I have read and agree to the above.

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Patient's Signature Date