Dr. Pam Wilson
Healing Bodies. Changing Lives.

FINANCIAL POLICY

130 Maple Avenue, Suite 7A
Red Bank, NJ 07701
Phone: 732-842-7004
Fax: 732-842-8799

Thank you for choosing Wilson Physical Medicine, LLC as your health care provider. The following is our financial policy, please read it carefully and sign. Thank you.

FINANCIAL POLICY

1. Payment is due prior to service being rendered. Please present photo ID and insurance card(s) at your initial check-in.
2. At the completion of your first office visit you will be asked to schedule your second appointment. In addition, we will discuss your insurance coverage and any other financial matters. At your second visit, Dr. Wilson (chiropractor) will inform you as to your examination results and whether or not you would benefit from chiropractic care, and recommend an appropriate treatment protocol based on your individual needs. If not, the appropriate referral will be made.

Please note the following:

a. Although we are an out-of-network provider for all insurance carriers, excluding Medicare, as a courtesy to our patients we will bill your insurance company and wait for their estimated payment. As the patient you will be required to pay your "time of service" payment at the beginning of each office visit. If the insurance company does not pay within 45 days (requirement by law), we will contact the insurance company and attempt to understand/correct the reason/problem for non-payment. If we do not receive payment in a timely manner from your insurance company, you will be immediately responsible for the set "cash fee for service" based upon the office fees at the time of the service. As a courtesy, we will provide you with information for the dates-of-service in question so you may pursue payment directly from the insurance company if you so desire.

b. If you do not have insurance, have not yet met your deductible, or if your insurance does not cover chiropractic care, we require your cash "time of service fee" payment in full at the beginning of each visit. The full time of service fee for a standard office visit is $130.00.

c. If for any reason you terminate care and treatment, any fees for professional services rendered to you will be immediately due and payable.

d. You will be billed $50.00 for any returned check.

e. If you fail to show up for a scheduled appointment and/or do not notify us at least 24 business hours prior to your scheduled appointment, you will be billed for the full amount of that missed appointment according to our customary fees as follows: $325.00 DNA or SpectraCell review one hour, $195.00 SpectraCell review 30 minutes, $285.00 initial consultation visit, $130.00 routine visit/care, 125.00 Medicare visit.

I have read the Financial Policy. I understand and agree to this Financial Policy.

_____ _____
Name Date

Certain services provided by Dr. Wilson at Wilson Physical Medicine, LLC are not reimbursable by Medicare. The charges for these services will be your responsibility as per Medicare Guidelines and explained in the Advanced Beneficiary Agreement (ABN)

I understand that certain services are not reimbursable by Medicare and that I may be billed for such services as rendered.

_____ _____
Signature of Patient or responsible party Date