



Patient Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

**A financial guarantor** is the individual responsible for paying all charges associated with the patient's care. This includes all fees, copayments, deductibles, and other related expenses.

### **Financial Policy:**

- ❖ I understand that verifying my insurance benefits is ultimately my responsibility. Although SunPointe Health's billing department may provide benefit estimates as a courtesy, these are not guarantees of payment. Final coverage decisions are made by my insurance provider, and I agree to be financially responsible for any uncovered charges. I also understand that billing my insurance is offered as a courtesy and does not relieve me of my financial responsibility for services received.
- ❖ I understand that it is my responsibility to ensure that my demographic information is accurate and up to date. If claims are denied or cannot be submitted due to outdated or missing demographic information, I acknowledge that the visit will be billed to me as a self-pay patient until the necessary updates are made. I also understand that insurance companies have strict timely filing deadlines, which vary by plan, and that failure to provide accurate information in time could result in my claim being denied and me being held responsible for the full cost of the visit.
- ❖ I understand that in order for SunPointe Health to properly bill my insurance, I must notify the office of any changes to my insurance plan before the day of my appointment. If I fail to provide updated insurance information in advance, I understand that I will be considered a self-pay patient until my new plan can be verified and confirmed to be in-network. I acknowledge that same-day verification may not be possible, and I may be responsible for payment at the time of service.

### **Rate and Fee Schedule:**

- ❖ I understand that all copays are due at the time of service. For telehealth appointments, I must have a credit card on file, and I consent to having my card charged by the office staff on the date of my appointment. If the card is declined or the copay is not paid, I understand that my upcoming appointment may be canceled or converted to an in-person visit. Continued failure to pay copays on time may result in my ineligibility for telehealth services.
- ❖ I understand that if my insurance plan includes a deductible, I will be required to pay a flat portion of the visit cost prior to my appointment. I acknowledge that this amount is an estimate, and additional charges may be billed after the claim is processed. I also understand that if I overpay due to having met my deductible, the excess amount will either be applied to future visits or refunded if I do not plan to return. For telehealth visits, I must have a credit card on file, and payment must be made on the date of the appointment. If payment is not received, my following appointments may be canceled or changed to in-person.
- ❖ I understand that the office reserves the right to hold or delay treatment if my account balance exceeds \$400, even if I have been making regular payments. I further acknowledge that if my account remains unpaid for more than 90 days, SunPointe Health may terminate my treatment.
- ❖ I understand that SunPointe Health is willing to provide assistance if the financial burden becomes too high or difficult to manage. It is my responsibility to contact SunPointe Health to request this assistance **before** my account balance reaches \$400 and/or becomes more than 90 days past due with no payments. I understand that if my balance exceeds these limits, it is my responsibility to bring the account current in order to continue receiving care at SunPointe Health. Billing may be reached at 814-867-8511.



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### **Self-Pay Policy:**

I understand that if I am paying out of pocket and make full payment on the day of my visit, I will receive a 20% discount. If I am unable to pay at the time of service, I will be required to pay a flat fee prior to the visit, and the remaining balance must be paid in full before my next appointment.

Service	Fee
No Show	\$70
Late Cancellation	\$45
Returned Check Fee	\$40
Base Rate for Self-Pay	\$76
Base Rate for Deductible	\$75

### **Clinical Policy:**

- I understand that Sunpointe Health requires that all appointments be cancelled no later than 24 business hours before the appointment is scheduled (Monday through Friday 8:00 am to 4:30 pm, excluding holidays).
- I understand that if I no-show or cancel an initial evaluation with our clinic with less than 24 business hours' notice, my file may be closed.
- I understand that I will be allowed 3 (three) late cancellations in a 12 month period. If this number is exceeded, I understand that my file may be closed.
- I understand that I will be allowed 3 (three) no-shows in a 12 month period. If this number is exceeded, I understand that my file may be closed.
- I understand that if I have commercial insurance I will be charged \$70 for any no-show appointment
- I understand that it is my responsibility to call the office at (814) 867-0670, or via our appointment reminder system, to cancel any appointment.
- I acknowledge that I have read, understand and will abide by the above policies and that if I do not, my file with Sunpointe Health may be closed.

I understand that as the financial guarantor, I am responsible for all charges not covered by my insurance. This includes, but is not limited to, copays, coinsurance, deductibles, fees and services not covered by my plan.

**Printed Name of Financial Guarantor (Must be 18 or Older):** \_\_\_\_\_

**Guarantor Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Relationship to Patient:** \_\_\_\_\_ **Phone #:** \_\_\_\_\_ **D.O.B.:** \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**Address - Street:** \_\_\_\_\_ **City:** \_\_\_\_\_

**State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_