Faith Home Care Practitioners, PLLC
34 NE Boistfort St. Ste. 123
Chehalis, WA 98532
360-996-4443 (Office) 855-619-1638 (Fax
www.faithhcp.com

Office and Financial Policies

- All professional services rendered by Faith Home Care Practitioners, PLLC are charged to the patient's insurance(s), unless the patient pays for a rendered service out of pocket. Most insurances do not pay for everything. If a service is not covered, the patient has the option of declining the service or all uncovered additional services will become the responsibility of the guarantor.

- All patients without insurance will be charged the full amount for all services provided.

- You will be asked to provide your insurance card(s) at every visit. This is to ensure that the information we have is correct and that your plan is current and one in which we participate in.

- It is the patient's responsibility to know your insurance benefits and whether the provider you are seeing is or is not a preferred provider.

- The patient or guarantor will be responsible for all co-insurances, deductibles, and copays. All copays are due at the time of visit.

- In order to release any medical records, we must have a release signed by the patient or guardian on file.

- Any send out lab work or portable diagnostic imaging will be billed from the reference lab or imaging company that performs the testing. Please direct all billing questions regarding labs or diagnostics to the company that performed the testing.

- We accept cash, credit cards, or personal checks as payment. You can contact the office to pay by credit card. There is a $30.00 fee on any returned checks.

Agreement to Accept Financial Responsibility, Insurance Authorization and Assignment of Benefits: I acknowledge that, at my request, Faith Home Care Practitioners, PLLC has provided or will provide myself or my dependent with professional services and I agree to the above financial policy. I also understand that if I fail to comply with this agreement, and my account becomes more than 90 days past due, it may be turned over to a collection agency, an attorney or small claims court for collection. I understand that any expense incurred by Faith Home Care Practitioners PLLC in its effort to collect claims will be added to my bill and become my responsibility. Additionally, I will not be able to be seen by the provider until my collection balance is paid in full. When you pay by check, you expressly authorize this merchant or its agents, if your check is dishonored or returned for any reason, to electronically debit your account for the amount of the check plus a processing fee not to exceed the state maximum legal limit. I hereby authorize Faith Home Care Practitioners, PLLC to furnish medical information to my insurance carriers for payment of claims. I hereby assign to the provider all payments for medical services rendered to myself or my dependents. I understand that I am responsible for any amount not covered by insurance.

Signature_____ Date_____

Printed Name_____ Relationship to patient_____