DelVal Integrative Health Partners, LLC
Rebecca Nice, DO

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Telford, PA 18969

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Payment Policy

We know that payment for medical treatment and insurance policy coverage can be a confusing process. We have established the following guidelines in order to help navigate the many aspects of health care. Please read it and ask any questions you may have. A copy will be provided to you upon request.

Insurance- We participate with most insurances. If you are not insured by a plan we participate with, payment is expected in full at each visit. If you are insured by a plan we participate with but your insurance card is not up-to-date, payment is expected in full at for each visit until we can verify your coverage. Insurances vary in their coverage and knowing your insurance benefits is your responsibility. There may be limitations and exclusions to your coverage. Our offices cannot guarantee that your carrier will pay your claim. If your claim with your insurance carrier is denied, you will be responsible for payment for the services rendered.

Co-payments and deductibles- All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance provider. Failure on our part to collect co-payments and deductibles from patients can be considered fraud.

Non-covered services- Please be aware that some (and perhaps all) of the services you receive may be non-covered or not considered reasonable or necessary by your insurance. You must pay for these services in full at the time of the visit. If an Advanced Beneficiary Notice (ABN) form must be signed in order to allow you to receive services not covered by your insurance carrier, no services will be provided until the form is signed. You will be responsible for payment in full for all services covered on the ABN.

Proof of insurance- All patients must complete our patient information form prior to seeing the doctor. We must obtain a copy of your driver's license/legal photo identification and current valid insurance card to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be held responsible for the balance of the claim.

Claims submission- We will submit your claims and assist you in any way we reasonable can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Your insurance benefit is a contract between you and your insurance company. We are not party to that contract.

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Coverage changes- Prior to each visit, we will ask you to verify your demographic information and insurance coverage and provide proof of insurance and identity. If your insurance changes, please notify us prior to your next visit so that we can make the appropriate changes to help you receive your maximum benefits. It is your responsibility to inform us of all such insurance changes, please notify us prior to your next visit so that we can make the appropriate changes to help you receive your maximum benefits. It is your responsibility to inform us of all such demographic (i.e., name, address, etc.) changes and all coverage changes to enable us to properly submit claims. If your insurance company does not pay your claim in 45 days, the balance will automatically be billed to you.

Nonpayment- if your account is 90 days past due, you will receive a letter stating that you have 20 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please beware that if a balance remains unpaid, we may refer your account to a collection agency and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30 day period, our physician will only be able to treat you on an emergency basis.

Missed appointments- Our policy is to charge $ 50.00 for appointments not cancelled within 24 hours prior to the schedule appointment time. These charges are you responsibility and will be directly charged to you.

We are committed to providing the best treatment for our patients. Thank you for understanding our payment policy. Feel free to ask if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by each and every provision contained herein

Patients Name
Date
Patient/Guardian Signature

- ❑ I understand a charge of $50 will apply If I miss or cancel an appointment without 24 hours notice.