Wellness In You, LLC
Financial Policy

Thank you for choosing our practice! We are committed to providing you with quality and affordable health care. It is the policy of **Wellness In You, LLC** to provide you with complete understanding of your financial responsibilities as an essential element of your care and treatment. Full payment is due at the time of service. For your convenience we accept cash or credit cards (i.e.; VISA, Mastercard, Discover and American Express). At the conclusion of your visits with us you may be billed for any outstanding balances. If there is a credit, you will be provided a refund within 30 days.

We are a **self pay only practice**, therefore we do not have an agreement with any insurance providers. Payment is due at time of services. If you would like to submit to your insurance company for reimbursement, we will provide you with a statement of services rendered services on an unassigned basis for you to send yourself. This means that your insurer will send the payment directly to you provided that you must pay for these services in full at the time of visit. We highly recommend that you also contact your insurance carrier and check into your coverage for services provided by **Wellness In You, LLC.**

Labs: Any labs ordered, you will have the option to have those services billed to your insurance by lab services.

Outstanding Balances: It is your responsibility to keep your account with us current. This includes all outstanding balances due billing statements received from us. You must pay these outstanding balances in full prior to seeing the practitioner for your next appointment. Non-receipt of a statement(s) from us does not excuse your obligation to pay your outstanding balance

Cancellations/Missed Appointments: Our policy is to charge a $25.00 missed appointment fee for any missed appointments not canceled within 24 hours prior to your scheduled appointment. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our financial policy. Please let us know if you have any questions or concerns.

I have read and understand the payment policy and agree to abide by its guidelines.

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Signature of patient or responsible party **Date**