HAKSHA
HEALTHCARE S.C

For Insurance Patients

333 Bishops Way • Brookfield, WI 53005-6226
PH: (262) 439-9544 FX: (262) 439-8933
Email: Hakshahealth@gmail.com

Patient Name (*print name*):

FINANCIAL POLICY

It is our goal to provide you and your family the very best service possible. As a service to our patients we are participating in a number of health plans, thereby making our services accessible to as many patients as possible.
Hereto is a summary of our financial and billing policies to identify our processes, whereby your signature below acknowledges understanding of our financial policies outlined below:

1) **FILED CLAIMS**: the office will file all claims for services rendered to primary and secondary insurances. *It is the patient's responsibility to furnish accurate, complete and current insurance information.*
2) **PAYMENTS:** we file secondary insurance claims for all our patients. However, in many cases secondary insurances will pay patients directly or your insurance policy has deductibles, coinsurances or similar provisions that will result in a non-payment for balances after your primary insurance has paid a claim. *We reserve the right to bill any unpaid balances directly to the patient if no payment from a secondary insurance is received within 60 days after filing.* These balances are due in full from the patient at the time of statement receipt.
3) **NON-PAR INSURANCE PROVIDER WAIVER**: there are instances whereas Haksha Healthcare S.C. may not be a participating provider with an insurance provider. Your insurance may be one that will not cover your visit with us as a participating provider. Upon verification of your insurance benefits and our findings you WILL BE notified of such case at time of your appointment. In this case, we will only bill you the Medicare Allowable amount at which time you are solely responsible for direct payment to Haksha Healthcare S.C.
4) **BILLING:** questions regarding the billing process, charges on your account or to update or change information have to be addressed to the office in *care of Billing Department.* **Inquiries via phone should be directed to our office at ( )** , to avoid delays in processing.
5) **CREDITS:** In cases where patients pay an open balance and payment from a secondary insurance is received for the same claim, the office will refund any credits resulting from such payment to the patient provided the total credit balance is equal or greater than $20.00. Credit balances less than $20.00 will remain on the account and will be used towards future balances or refunded once the total credit amounts reach $20.00.
6) **INSURANCE CO-PAYS**: Because of the variety of different plans and contracts insurances have and the constant changes within each plan, we cannot be held responsible for the accuracy of co-payments collected. **In rare cases we have discrepancies between collected amounts and the amounts your insurance contract requires.** Adjustments of this nature will be made at the time the insurance notification is received and either credited to patient's account or billed to the patient.
7) **COLLECTIONS**: We try to work with patients to find ways to make the payment process as easy as possible. *However, if we do not receive payment after the stated grace period, accounts may be evaluated for further collection process and the office may consider discharging a patient from the practice for non-payment(s).*

CANCELLATION POLICY

You have been scheduled for an appointment with Dr. Kshama Bhat for an initial or follow up consultation at our clinic.
As it is our mission to provide the best service to our patients, we do enforce a 24 HOUR CANCELLATION NOTICE/ No Show Policy at our practice as we have patients who may at times be waiting weeks for their scheduled appointment.

Below is our NO SHOW /CANCELLATION Policy outline for your understanding:

1.) We request out of respect for other patients waiting for appointment(s), **please notify our office at least 24 Hours prior to your appointment date if you must CANCEL OR RESCHEDULE**. We are available to assist with rescheduling.
2.) If you do not contact our office, and are a **NO SHOW** at your scheduled procedure date/time you **WILL BE BILLED A $10.00 cancellation/no show fee** due to the cost involved for preparations of your scheduled appointment.

PATIENT ACKNOWLEDGEMENT

We sincerely hope these policies promote our overall goal of transparency and team-oriented health care. Please feel free to let us know if there are any items we can improve to make the administrative side of our practice as painless and easy for you as possible.

By my signature below, I acknowledge to have read the above polices and agree to the terms outlines. I understand my responsibilities and the consequences for violation of the financial or cancellation responsibilities. I was given opportunity to ask questions regarding the financial and cancellation policies and understand their impact on my relationship to the practice.

Patient Signature (*or legal guardian, please identify below*):	Date:
If signed by a legal guardian above, please print name and relationship to patient:	Relation: