VITAE
INTEGRATIVE MEDICAL CENTER

Financial Policy & Billing Practices

Medical services provided by Vitae Integrative Medical Center are payable at the time of service. We accept the following forms of payment:

- Checks
- Cash
- Debit / Credit / Health Savings Account Card

Insurance is billed as a courtesy for our patients. All copays, co-insurances, and deductible amounts are due at the time of service. Vitae Integrative Medical Center is contracted with the following insurance companies:

- Blue Cross Blue Shield
- Aetna
- Cigna
- United Healthcare

Please note that it is the patient's responsibility to know, verify, and understand their insurance benefits. In certain circumstances or at the patient's request Vitae may verify benefits but quotes are never a guarantee of coverage. If at any time there is a dispute between the patient and the insurance company, the balance will be the patient's sole responsibility. All NSF checks will be assessed a $25 fee.

Payment by checks should be sent to: 2925 Debarr Rd. Suite 150 Anchorage, AK 99508.

Payment plan options are available under certain circumstances. If you are in need of a payment plan please contact our billing department. Payment plans are available in 3, 4, or 6 month terms. Our preference is to work with our patients as much as possible; however any delinquent account balances will be forward to our collection agency: Transworld Systems Incorporated. Balances that are transferred to Transworld Systems Incorporated may be assessed additional fees by the collection agency. Accounts are considered delinquent after 120 days from the date of service.

Self-Pay patients are required to pay at the time of service. Self-Pay patients are required to keep a card on file at all times. An active card must be on file for the patient to schedule. The card on file will be charged after the patient's visit.

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Due to our high volume of patients and the desire to accommodate and respect the time of both our patients and providers we ask that you contact the office 24 business hours prior to your scheduled appointment before cancelling or rescheduling. **If you fail to contact the office within 24 business hours of your appointment time, you will be assessed a $50 fee.**

_____ ***(initial)*** I have read and understand the cancellation / no-show policy above.

I request that payment of authorized insurance benefits be made to Vitae Integrative Medical Center for any covered services furnished by Vitae Integrative Medical Center. I agree to pay Vitae Integrative Medical Center for all deductibles, co-pays and/or co-insurances on my claim. I have read and understand the above policies.

_____ _____

Signature of Patient, Guardian, or Legal Representative **Date Signed**

_____

Printed Name

Telephone: (907) 929 - 2222
Fax: (907) 929 - 2225

2925 Debarr Rd. Suite 150
Anchorage, AK 99508

www.vitaeheal.com