RAVINDER SINGH, M.D.
Board Certified in Family Medicine

BARBARA SANTA CRUZ, PA-C

Rancho Wellness Financial Policy:

We appreciate that you have entrusted us with your health care. Because healthcare benefits and coverage options have become increasingly complex, we have developed this policy which details our financial requirements to help you better understand your responsibilities as a patient.

It is your responsibility to know if your insurance has specific rules or regulations, such as need for referrals, precertifications, pre-authorizations, limits on outpatient charges, specific physicians or hospitals to use. you should be knowledgeable of any deductibles, co-payments, and co-insurance. This applies to all payrolls regardless of whether or not our providers participate.

The responsibility for payment of fees for services is the direct responsibility of the patient. Your health benefit plan is an arrangement between you, the enrollee and the insurance company, HMO or your employer. Your health benefit plan determines your coverage, requirements, and establishes the limit on your coverage for medical services based on what they determine as medically necessary. However, we will do our best to assist you with understanding your proposed treatment and in answering questions related to your insurance.

PAYMENT POLICY SCHEDULE:

Co-payments	**Full payment due at time of service**
Deductible and coinsurance	**Full payment due at time of service**
Non-covered service	**Full payment due at time of service**
Non-paricipating insurance plan	**Full payment due at time of service**

CANCELLATION/NO SHOW POLICY

We understand there may be times when you miss an appointment due to emergencies. We urge you to call 24 hours prior to cancelling your appointment. Failure to do so may result in a charge of $35.00.

If you no show for two consecutive appointments or cancel for a total of four appointments without notification, you will be discharged from care.

CONSENT FOR TREATMENT AND AUTHORIZATION TO RELEASE INFORMATION:

We require your authorization to perform appropriate assessment and treatment procedures and to release any information acquired in the course of your exam and treatment to the appropriate agencies for billing purposes.

Patient/Guarantor

Signature ______________________ Date ______________________

10837 Laurel Avenue, Suit 200, Rancho Cucamonga, California 91730

Phone: (909)483-7800 . Fax: (909) 483-0760

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We would like to thank you for choosing Rancho Wellness as your primary care provider. We are committed to providing you quality and efficient health care with a smile. In an effort to provide you with the best possible experience during your office visit we will implement a new payment policy. Please review it, ask us any questions you may have, and sign in the space provided.

Knowing your insurance benefits, including your co pay and yearly deductibles, is your responsibility. You must provide us with up-to-date insurance information at each visit. In the event that verification cannot be established you will be responsible for the full office visit payment.

All co-payments are due at time of service. No exceptions. We do not accept checks.

All deductibles are due at time of service. If you have a yearly deductible to met, a credit card will be kept on file securely, and a deposit towards that visit will be collected at time of visit. The remainder balance will be charged only once the explanation of benefits has been received from your insurance company. If you would like a receipt please indicate at the bottom of the page and it will be emailed to you following payment.

If your insurance company does not pay your claim in 60 days, balance will automatically be billed to you.

Our practice is committed to providing the best possible care to our patients. Thank you for understanding our payment policy.

I have read and understand the payment policy and agree to abide by its guidelines:
yes No

______________________________ ____________________ ______________________________

Signature of patient or responsible party | Date | receipt emailed

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