



The team at Alivation Health strives to exceed expectations in treatment and services to make your experience with us as comfortable and stress-free as possible. To do so, we have implemented several policies that we would like you to be aware of.

PLEASE INITIAL EACH ITEM.

___ **PROVIDER:** To ensure you receive the best care, your provider may change during treatment. Reasons for this may include insurance changes, provider specialty, or provider availability.

___ **COPAYMENTS:** Copays are due at the time of service, if you are unable to pay at the time of service you will be asked to reschedule your visit.

___ **SELF-PAY PATIENTS:** If you do not have insurance, your balance is due at the time of your office visit. If you are unable to pay at time of service, you will be asked to reschedule.

___ **INSURANCE CARDS:** Insurance cards are required at every visit. If you have not provided our office with the correct insurance information, you will be responsible for any balance due.

___ **MONTHLY BILLING STATEMENTS:** Every month our office sends out a monthly billing statement to every patient. The balance due is the remainder owed after your insurance has paid.

___ **COLLECTIONS:** If your account balance is unpaid and overdue after three attempts, to contact you and you have not responded to any of our attempts to contact you, your account will be referred to a collection agency. Once your account is in collections, you will be dismissed from our practice which includes refill requests and appointments.

___ **PAYMENT PLANS:** If you have negotiated a payment plan with us you are responsible for making timely and consistent monthly payments. If you fail to make your scheduled due date, your account will be sent to collections for non-payment.

___ **LATE FOR APPOINTMENTS:** If you arrive more than 15 minutes late we may need to reschedule your appointment or we may ask that you wait until the next open spot in the schedule while we continue to see the patients who arrived on time.

___ Our staff will treat all patients with the upmost respect and professional attitude. In return, we expect our patients to be courteous in our office. If a patient is consistently uncooperative, refuses to follow treatment plans, or uses demanding and abusive language our staff have the right to dismiss a patient from our practice for non-compliance.

I have read and understand all above policies.

SIGNATURE: _____

DATE: _____

PRINT NAME: _____

EMAIL ADDRESS: _____

DATE OF BIRTH: _____



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