Sapphire Health and Wellness

"Patient Responsibilities and Financial Policies"

Please read, sign and date the bottom

1. It is the patient's responsibility to know your insurance benefits and policy requirements for office visits, procedures and vaccinations.
2. It is the patient's responsibility to bring your current insurance cards(s) and method of payment to each office visit.
3. It is the patient's responsibility to update your insurance information, current address and contact information for our records. Failure to do so will cause the patient to become responsible for all charges.
4. It is the patient's responsibility to notify our office 24 hours prior to your scheduled appointment if you are unable to keep your appointment. Failure to do so will result in a $25 no show/cancelation fee which must be paid prior to scheduling your next appointment.
5. It is the patient's responsibility to fully participate in decisions involving his/her own health care and to accept the consequences of those decisions.
6. I understand and agree, to pay all copays, co-insurance, deductibles or "cash pay" estimated amounts at the time of service.
7. I understand that a copy of my explanation of benefits (EOB) will be sent to me by my insurance company when my claims are processed.
8. I understand it is my responsibility to pay all balances within 30 days after my insurance has paid their portion.
9. I understand that if for any reason my insurance company does not pay for services within 90 days of the services being provided, I shall assume responsibility for the total amount owed.
10. I understand if my account is not paid within 30 days from the date of my final billing statement that my account will be referred to a collection agency and I will be discharged from the practice.
11. I understand that if I do not have my insurance card with me at my appointment that I will be required to pay, the current Self Pay office visit fee, up front.

I hereby authorize my insurance benefits to be paid directly to Sapphire Health and Wellness LLC, realizing I am responsible to pay all non-covered services, which shall include all outside labs, x-rays, specialists or non-contracted facilities. If proper & current insurance information is not given, I will be responsible for all charges. I hereby authorize the release of pertinent medical information to insurance carriers. I understand if this account should become delinquent & referred to a collection agency, I will be responsible for any collections or legal fees.

_______________________________________ Patient Name (please print)

_________________________ Date of Birth

_______________________________________ Patient Signature (or parent/guardian if under 18)

________________________ Date

3530 S Val Vista Dr. #A111, Gilbert AZ 85297
(480) 219-7810 (P)
(480) 219-7806 (F)
Info@sapphirehealthaz.com