FINANCIAL POLICY

The Kutcher Clinic requires payment, including outstanding balances, at the time of service – unless other arrangements have been made.

INSURANCE

Insurance reimbursement of Kutcher Clinic fees is not guaranteed and is between the patient and their insurer.

Patient Responsibility: Insurance is a contract between the patient and their insurance company. It is the patient's responsibility to understand the financial terms and details of their plan, including, but not limited to: covered and non-covered services (ex: nerve block injections,) reimbursement, deductibles, out-of-network benefits, and potential out-of-pocket costs. In the event the patient's insurance denies a service, charges will be patient responsibility.

Clinic Responsibility: Kutcher Clinic will supply necessary billing information, including a "superbill", upon request, but we will not communicate with the patient's insurance company on the patient's behalf. All discussions regarding benefits and reimbursement must be handled directly between the patient and their insurer.

SUPERBILL

A "superbill" is an itemized receipt used by a patient to submit to their insurer for possible reimbursement. While Kutcher Clinic will provide an electronic copy of a "superbill", to the applicable fee-for-service patients, reimbursement by your insurance is not guaranteed, and is between you and your insurer.

NO SHOW AND LATE CANCELLATION

"No Show" is defined by not arriving online (for telehealth) or in-person for the scheduled appointment and not communicating with the Kutcher Clinic staff, via phone, voicemail or portal message prior to the appointment. NO SHOW FEE IS $100.

"Late cancellation" is defined by canceling or re-scheduling your appointment with less than 24 hours notice provided to the Kutcher Clinic staff via phone, voicemail or portal message. LATE CANCELLATION FEE IS $50.

CARD ON FILE

All Kutcher Clinic patients (with exception of First Care Medical patients on a lien) will be required to have a "card on file" agreement. I agree to allow Kutcher Clinic to charge this card for applicable fee-for-service charges and other clinic fees, as outlined above.

I understand that my card on file information will be securely stored by Kutcher Clinic and/or their trusted service providers to facilitate collection of payments.

I understand that I can make changes to this "card on file" authorization by contacting Kutcher Clinic.

By signing below, I acknowledge that I have read and understand the financial policy stated above.

PATIENT CONSENT	
Patient Name:	Date of Birth:
Parent/Guardian Name:	Relationship:
Patient/Guardian Signature:	Date:

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