



# PELTS, KIRKHART ASSOCIATES, LLC

## FINANCIAL POLICY AGREEMENT

We believe that everyone benefits when there is a definite and clear understanding of our financial policy prior to treatment.

1. **ALL** clients are expected to pay in full at the time of service. It is the client's responsibility to contact their insurance company for any and all authorizations and reimbursement determinations. Pelts- Kirkhart will file claims as a courtesy at the end of each month.
2. **ALL Pelts, Kirkhart & Associate Providers** are **fee for service** and it is understood that the client/responsible party is liable for the cost of treatment. The client/ assigned responsible party is accountable for all payments as well as updating any and all changes regarding financial information and this policy agreement.
3. **MEDICARE OPT OUT:** Pelts, Kirkhart and Associate Providers have formally opted out of Medicare. Therefore, claims for services with Providers **cannot** be filed with Medicare by the client or the business office. A Medicare Opt Out Private Contract will be signed and maintained.
4. **AS A COURTESY**, we will file insurance claims for all commercial plans at the end of each month. We **can not** file secondary insurance, Medicare Replacement plans, Medicaid, Tricare or any other Federally Funded Insurance plans, as noted in #3 above.
5. **APPOINTMENT REMINDERS** are a courtesy provided by our office. All scheduled appointments are the client's responsibility.
6. **CANCELLATION POLICY:** There is a broken appointment charge for any patient who cancels with **less than 24 hour** notice or who does not present at the appointed time. You will be charged **100%** of the total missed appointment fee.  
  
**Please Note:** Requests for cancellations or rescheduling of appointments must be done by a representative of the office between 8:30 am and 5:00 pm Monday through Friday. Messages left on the voicemail cannot be honored.
7. **NON-SUFFICIENT FUNDS CHECK POLICY:** An NSF fee of \$35 will be charged for all returned checks including any and all bank fees that apply.
8. **SCHOOL OBSERVATIONS** or court-related fees or other services provided out of the office are to be paid in full at the time of the initial appointment or prior to the visit being scheduled.
9. **BALANCES:** You are encouraged to call our office if there are any questions about this information. If there is a credit card on file, outstanding balances will be charged to that card.
10. **QUESTIONS:** You are encouraged to call our office if there are any questions about this information. If, at any time during your course of treatment, problems with this financial policy arise, you are encouraged to speak with your clinician or to contact the Office Manager.
11. **A COLLECTION AGENCY** will be engaged if you have an outstanding balance which we have been unable to negotiate or collect.

**For your convenience we accept cash, personal checks, and most major credit cards. I have read and agree with these terms.**

Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

Name of Client: \_\_\_\_\_

# PELTS, KIRKHART ASSOCIATES, LLC

Client Name: \_\_\_\_\_

Client Of: \_\_\_\_\_

## Appointment Reminders

Email reminders for clients of Dr. Pelts, Dr. Wuttke & Dr. Hayne are sent from

[DoNotReply@myscheduler.net](mailto:DoNotReply@myscheduler.net)

## Appointment Reminders

Email reminders for clients of Dr. Kirkhart, Dr. Labat, Dr. Blackell, Dr. Asher, Lee Hoffman,  
Nancy Timm & Renee Boyer are sent from

[No-reply@simplepractice.com](mailto:No-reply@simplepractice.com)

(please add addresses above as an allowed address in your email settings to make sure they are received)

Dear Client,

As a client of Pelts, Kirkhart and Associates, you can receive an appointment reminder to your email address, or your cell phone, or text message for reminders from Simple Practice two days before your scheduled appointments. Any changes to your scheduled appointment must be made by phone prior to 5 pm on the previous business day.

Your email address: \_\_\_\_\_

Your cell phone number: (\_\_\_\_) \_\_\_\_\_

Your cell phone carrier (circle one):

AT&T                  Alltell                  Sprint                  Boost Mobile                  Nextel

T-mobile      Verizon      VoiceStream      (Other) \_\_\_\_\_

I would like to receive my appointment reminders: (Choose as many as you like.)

Via email message to the address listed above and

Via text message to my cell phone (normal text message rates will apply)

\*\*not currently available for Dr. Pelts, Dr. Wuttke, or Dr. Hayne.\*\*

Via telephone message to my cell (please make sure voicemail is available to leave msg)

None of the above. I'll remember my appointment on my own.

(Missed appointment fees will still apply)

Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private, and requesting that it be handled as I have noted above. Appointment reminders are a courtesy offered by Pelts, Kirkhart and Associates with the client being responsible for missed appointments and associated fees.

\_\_\_\_\_  
Client / Parent Signature

\_\_\_\_\_  
Date

# PELTS, KIRKHART ASSOCIATES, LLC

## INSURANCE INFORMATION

WE WILL NEED A COPY OF YOUR INSURANCE CARD IF INSURANCE IS TO BE FILED

Provider: \_\_\_\_\_

Client name: \_\_\_\_\_

### **Insurance Information:**

Subscriber's name: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_

Subscriber's DOB: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Member #: \_\_\_\_\_

Group #: \_\_\_\_\_

Group Name (Employer): \_\_\_\_\_

\*\*\*\*\*

### **Please provide the following, if different from client:**

Subscriber's Address: \_\_\_\_\_

Subscriber's Telephone #: \_\_\_\_\_  
Home Cell Work

I authorize the release of any medical or other information necessary to process this claim. **Verification / Prior Authorization of Benefits is client responsibility.**

### **PLEASE BRING YOUR INSURANCE CARD OR PROVIDE A COPY**

**I understand it is my responsibility to update any insurance information changes.**

\_\_\_\_\_  
Date

\_\_\_\_\_  
Responsible Party Signature

# PELTS, KIRKHART & ASSOCIATES, LLC

## Insurance Filing Policy

(Adopted October 2018)

1. Pelts, Kirkhart & Associates files commercial primary insurance claims at the end of each month/beginning of the following month as a courtesy to our clients.
  - We do not file secondary insurance, but upon request can supply you with a superbill so you may file claims with your secondary plan.
2. We only file with commercial insurance plans as our providers have formally opted out of Medicare. A Medicare opt-out form must be completed for any client that has Medicare or a Medicare Replacement plan as their insurance. The Medicare opt-out form will be kept in the client's file and must be renewed every two years.
  - Pelts, Kirkhart & Associates will therefore not file for or provide you forms to file the following insurances since they are not eligible for reimbursement:
    - Medicare
    - Medicare Replacement Plans
    - Medicaid
    - Tricare
    - Secondary Insurance Policies

# PELTS, KIRKHART & ASSOCIATES, LLC

Client of: \_\_\_\_\_

Client of: \_\_\_\_\_

## CREDIT CARD AUTHORIZATION FORM

Client Name: \_\_\_\_\_

Cardholder's Name: \_\_\_\_\_

Card number: \_\_\_\_\_

Type of card: \_\_\_\_\_ Expiration Date: \_\_\_\_\_

Billing Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Telephone: \_\_\_\_\_

CVV Code: \_\_\_\_\_

Use for All Sessions (when card is not available)

One Time Use Only

\_\_\_\_\_  
Cardholder Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Other Authorized User

\_\_\_\_\_  
Relationship to Client

I authorize the use of this credit card for payment as a convenience when the actual credit card is not available at time of service. This card may also be used for missed appointments and balances on account. I will update this information as needed.