Account #: _____

SUNPOINTE HEALTH

# Financial Policy

**Guarantee of Payment:** I agree to pay all applicable charges, which are not paid in full by my insurance. If amounts due to SunPointe Health are not paid according to this financial policy, the account will be deemed delinquent. In the event that I default on payment of my account, I understand I am responsible for any and all costs incurred on the collection of my account, including court costs and reasonable attorney's fees. If the debt is assigned to a third party collection agency, I agree to be responsible for collection fees and interest due to amounts in default.

- **I agree to provide all information required by SunPointe Health and my insurance company for billing purposes. I understand that if this information is not provided in a timely manner, I may be responsible for any amounts denied by my insurance company, and SunPointe Health has the right to pursue termination of treatment.**

- **I agree to provide SunPointe Health with a valid credit card number to be used for each appointment and for any patient amount due. Appointments will be scheduled only after payment in full is received. (Specific Credit Card on File policies are outlined on the Credit Card Authorization on the next page.)**

- **I agree to pay the following fees, if applicable:**
  - Returned Check Fee- $40
  - No-Show Fee- $70
  - Late Cancellation Fee- $45 (If less than 24 hours)
  - After hour's crisis/urgent calls to your clinician or clinician on call (cost depends on length of call and needed intervention.)

- **I understand that it is my responsibility to verify my insurance benefits. Any quote of benefits obtained by SunPointe Health is provided as a courtesy by our billing department. We do our best to obtain accurate information, but we cannot guarantee that claims will process according to quoted benefits.**

- **If at any time, I am unable to pay my balance in full, I agree to contact the patient accounting department to establish a repayment agreement.** SunPointe Health reserves the right to pursue termination of treatment for financially delinquent accounts. (Those that are not receiving regular monthly payments on existing balances.) **(Patient Accounting Direct line: 814-272-3121)**

**Printed Name of Guarantor (Must be 18 or Older)**: _____**Guarantor Signature**:_____

**Printed Name of Patient (if different than Guarantor)**:_____ **Date: ____/____/____**

*****No person under the age of 18 may sign under Guarantee of Payment.*****

**Guarantor Information (if person other than patient):**

**Relationship to Patient**: _____ **Phone #**:_____ **D.O.B**: **____/____/____**

**Address -** Street:_____ City: _____ State: _____ Zip: _____

**Signature of Witness:**_____ **Date: ____/____/____**