Amy S. Elder APRN, WHNP-BC
591 N Knik Street, Suite E
Wasilla, Alaska 99654
Phone: 907-203-0044 Fax: 907-331-0505
Email: office@karisalaska.com

Patient Financial Responsibility Policy

Thank you for choosing KARIS Integrative Medicine, LLC for your medical needs. Please read the information below and sign the form at the bottom to confirm your understanding of our financial responsibility policy.

We will complete an initial verification of your benefits once we receive a copy of your Insurance Card with your policy number (or member ID). This is being done to provide the most accurate information to you at the time of your visit, regarding your financial responsibility. Please note that our office has a $25.00 late cancel and/or no-show fee policy, if you do not attend your appointment or cancel your appointment with less than 24 hours' notice.

In-network vs. out-of-network providers - definitions

In-network:

- A provider that has a contractual relationship with a health plan or issuer for the item or service provided.
- KARIS Integrative Medicine, LLC is in-network with BCBS, Aetna, Cigna, Medicaid, Meritain, & Allied Benefit Systems.

Out-of-network:

- A provider that doesn't have a contractual relationship with a health plan or issuer for the item or service provided.
- KARIS Integrative Medicine, LLC is out-of-network with all Insurance Companies not listed above.
- We have opted out of Medicare and therefore are unable to bill Medicare for any of the services you receive in this clinic.

The above means that if you are covered by one of the listed out-of-network plans, you will be responsible for payment of the fees associated with your visit today, however, we can bill your insurance as a courtesy. If your insurance plan makes payment to KARIS Integrative Medicine, you will be refunded the amount your plan pays.

KARIS Integrative Medicine, LLC Fee Schedule for cash (or out of network plan) patients is $500.00 per hour for services rendered on the date of your visit. Payment is appreciated at the time services are rendered unless other arrangements have been made in advance. There is a standard NO SHOW fee of $50.00 for any appointment not canceled with 24 hours notice.

By signing below, I _____understand that I will be responsible for any copays or deductibles due as verified on the date that I receive services from KARIS Integrative Medicine, LLC. I further understand that if my outstanding balance is not paid in full within 90 days of my first statement, my account may be turned over to collections. Please speak to a member of our staff if you need to discuss payment arrangements.

PATIENT SIGNATURE: _____ DATE: _____

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CREDIT CARD AUTHORIZATION FORM

Credit Card Information
Card Type: ____Mastercard ___Visa ___Discover ____AMEX
Cardholder Name (as shown on card):
Card Number:
Expiration Date (mm/yy): CVV Code:
Card holder Zip code (from card billing address):

By signing below, I _____ authorize KARIS Integrative Medicine, LLC to charge my credit card above for balances owing on my account. I understand that my information will be saved on file for use in future transactions.

PATIENT SIGNATURE: _____ DATE: _____