Connecticut Addiction Medicine
Way to Recovery

PATIENT PAYMENT POLICY

Connecticut Addiction Medicine LLC strives to ensure that our patients have a clear understanding of their financial responsibility with respect to the medical services we provide. These policies apply to all procedures and treatments.

Insurance: Your insurance policy is an agreement between you and your insurance company. We are not a party to your contract. As a courtesy, we will bill your health insurance plan for you, as long as you provide us with accurate information. Please contact your insurance company with any questions you may have regarding coverage, deductibles, co-pays and similar items.

Non-Contracted Insurances: If we are not contracted with your insurance company, please be advised that your out-of-packet costs may be greater than originally anticipated. We will give you an estimate of costs, but the final amount due will be determined by reimbursement from your insurance company.

Non-Covered Services: Please be aware that some of the services performed by our office, for your benefit, are not covered or may not be considered reasonable or necessary by Medicare or other insurers. We suggest you contact your insurance carrier to verify your benefits and understand any non-covered services as these will be your financial responsibility. Payment will be required prior to your appointment.

Insurance Card: Patients must present a valid insurance card and driver's license (or other form of valid identification) at the time of arrival. It is your responsibility to notify us about insurance changes immediately so we can make the appropriate changes to your billing information. If you fail to provide us with the correct insurance information in a timely manner, you will be responsible for all incurred charges.

Co-Pay: ***All co-payments must be paid at the time of your visit. This arrangement is a part of your contract with your insurance company.*** Failure to pay at the time of service may result in re-scheduling of your appointment/group therapy until funds are available. We reserve the right to refuse treatment to patients who fail to pay the applicable co-pay.

Payments: We will bill your insurance company as a courtesy to you, but this billing service does not preclude your financial responsibility for the medical treatment received. Any deductible, co-insurance or non-covered services, including ineligibility are your responsibility. We accept Cash, Checks, Debit/Credit cards for your convenience. We will send patients' accounts to collections for balances not paid after receipt of two statements unless you make a payment arrangement with our office. We reserve the right to require payment for services to be made at or

before the time of service. Our office charges a $ 35.00 (thirty-five) dollar fee for all accounts closed, stop payment or non-sufficient funds returned checks.

Outstanding Balances: We reserve the right to refuse to see patients with outstanding account balances over $ 100.00 until a payment plan is established with a minimum payment of $ 25.00/week. Balances over $ 250.00 will require a minimum payment of $ 50.00/week. Please be aware that the failure to establish a payment plan may lead to discharge from the practice for non-compliance.

Appointment Cancellation/ No Show/ Reschedules: If it is necessary to cancel your scheduled office appointment/group we require at least 48 hours advance notice.
To cancel appointment call the CT Addiction Medicine, LLC at (860) 757-3874.

A failure to be present at the time of a schedule appointment/group will be recorded in the patient's chart as a "no show". Three incidence of non-compliance will lead to discharge from the program at the discretion of the provider.

Late Arrivals: In order for our doctor to see their patients in a timely manner, your help in arriving promptly for your appointment is required. If you are more than 10 minutes late, our office may reschedule your appointment to a new date and time. Tardiness affects your patient care as well as those patients that have a scheduled time after you.

Attestation Statement:

I have read, understand, and agree to the above Connecticut Addiction Medicine, LLC Payment Policy.

I understand that charges not covered by my insurance company, as well as applicable co-payments and deductibles, are my responsibility. I acknowledge that these policies do not obligate Connecticut Addiction Medicine LLC to extend credit.

I authorize Connecticut Addiction Medicine LLC to release pertinent medical information to my insurance company when requested, or to facilitate payment of a claim.

Print Name of Patient	Print Name of responsible party if minor
Signature of Patient (or responsible party if minor)	Date