BALANCED HEALTHCARE CENTERS
1414 S. OAK AVE. STE. #4
OWATONNA, MN 55060
507-455-0199 FAX: 507-455-9224

2024 AUTHORIZATION OF PAYMENT AND STATEMENT NOTICES

BALANCED HEALTHCARE CENTERS do not mail statements.

_____ **Option 1**

We can store a credit card number securely in the cloud. Deductibles and copays will be billed to your credit card on the day the services are rendered. A balance due after insurance processes can be billed to your credit card and a receipt can be emailed to you.

Email Address: _____

Your card will be billed the first week of the month. If the credit card becomes invalid, or the expiration date is expired you will receive a balance due statement via email or by text message.

Cell #: _____

_____ **Option 2**

You have paid the good faith estimates on the day the services were rendered, but after the insurance has processed there is a balance due. We will send a statement via email. The statement will not include a diagnosis or PHI. It will include payments received and balance due.

Email Address: _____

IF AN ACCOUNT BECOMES DELIQUENT AND A PAPER STATEMENT IS MAILED, **THERE WILL BE A $4.00 STATEMENT FEE CHARGED** TO COVER OUR COSTS FOR PREPARING AND SENDING THE STATEMENT. Any outstanding account balance over 60 days will incur a service charge at the rate of 1.5% monthly or 18% annually.

_____ _____

Patient's Name (Please Print) Date of Birth

_____ _____

Signature of Responsible Party Date

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ACKNOWLEDGMENT OF RECEIPT OF HIPAA PRIVACY NOTICE

_____ BY INITIALING, I ACKNOWLEDGE THAT **I HAVE BEEN OFFERRED** THE NOTICE OF PRIVACY PRACTICES OF BALANCED HEALTHCARE CENTERS.

_____ BY INITIALING, **I HAVE RECEIVIED** A COPY OF THIS OFFICE'S NOTICE OF PRIVACY PRACTICES. I understand that I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

1. Conduct, plan and direct my treatment and follow-up among the health care providers who may be directly and indirectly involved in providing my treatment.
2. Obtain payment from third party payers.
3. Conduct normal health care operations such as quality assessments and accreditation.

Patient _____

Signature _____ Date_____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgement could not obtained because:

____ Individual refused to sign

____ Communications barriers prohibited obtaining the acknowledgment

____ An emergency situation prevented us from obtaining acknowledgment

____ Other _____
_____

Staff Signature _____ Date_____