BLATMAN
HEALTH AND WELLNESS CENTER

Financial Policy

Welcome to Blatman Health and Wellness Center (BHWC). We appreciate the opportunity to care for you. This policy explains how our business office operates and outlines your financial responsibilities as a patient. If you have questions regarding fees or payment requirements, please contact our financial coordinator.

Payment Methods

Payment for all services is due at the time of the visit. We accept cash, money orders, and all major credit cards.

Appointments

New patient appointments require a two-hour reserved time. New patient visits must be cancelled at least two business days in advance (excluding Fridays) to avoid the $100 cancellation fee. Established patient appointments must be cancelled at least 24 hours in advance. Missed appointments or late cancellations will incur a $65 fee, which must be paid before scheduling your next visit. If an account becomes delinquent and must be sent to a collection agency, a $20 collection fee, plus any associated external costs, will be added. All fees are subject to change without notice.

Current Balances on Patient Accounts

Any patient balance that becomes 30–60 days past due must be paid in full before additional appointments may be scheduled.

Attorney / Accident Cases / Insurance Reports / Disability Forms

Requests for records or documentation sent to attorneys, insurance carriers, or third parties must include a written request and your authorization for release. Disability forms require a fee of $35 for the first form and $20 for each additional form. Narrative reports and letters, including BWC documentation, incur additional fees depending on complexity. Processing typically takes 7–10 business days.

Confidentiality

Your medical records are confidential. Information will not be released to family members, employers, attorneys, or other healthcare providers without your written authorization. Ohio Bureau Workman's Compensation (BWC) patients have already authorized release of records as part of their claims process.

Insurance

BHWC does not participate in any insurance plans. Most insurance networks do not fully cover the types of services we provide. You are responsible for contacting your insurance company in advance to determine whether your plan offers any out-of-network benefits. As a courtesy, BHWC can help you submit a claim to your insurance company upon request; however, your insurance policy is a contract between you, your employer, and your insurer, and all charges remain your responsibility on the date services are rendered. If temporary financial difficulties arise, please contact us promptly so that we may assist with payment arrangements.

Medicare/Medicaid opt-out agreement

BHWC has formally opted out of Medicare and Medicaid. Claims cannot be submitted to Medicare or Medicaid, and patients may not seek reimbursement from these programs for services received at BHWC. Please contact our office if you have questions about how this affects your care.

By providing my signature below, I acknowledge and agree to the following: BHWC, including Dr. Hal S. Blatman and all associates, has opted out of Medicare and Medicaid under Sections 1128, 1156, or 1892 of the Social Security Act. I understand that services received at BHWC cannot be billed to Medicare or Medicaid, and no reimbursement will be made by these programs for any services provided here. I accept full financial responsibility for all charges associated with my care.

I understand that I am not required to receive services at BHWC and that I may obtain Medicare- or Medicaid-covered services from physicians or practitioners who have not opted out of these programs. I understand that BHWC intends to remain opted out of Medicare and Medicaid indefinitely. I also understand that Medigap and other supplemental insurance plans may choose not to cover services not paid for by Medicare or Medicaid.

By providing my electronic signature, I confirm that I have read, understand, and voluntarily agree to the terms of this Medicare/Medicaid opt-out agreement and this Financial Policy of BHWC.

Patient Name: _____ **Date:** _____

Patient Signature: _____