Northwest
INTEGRATIVE MEDICINE

Statement of Financial Responsibility

Please initial and sign to acknowledge that you have read and understand the clinic's financial policies.

_____ A **$50 non-refundable appointment holding fee is required at time of scheduling** and will be applied towards my visit.

_____ I acknowledge that if I do not give adequate cancellation notice I will be charged **a missed appointment fee of $50**. This is regardless of any discounts I am receiving.

_____ I acknowledge the office visit fees for new or returning patients **does not include** medicinary items, lab work and tests, or physician ordered add-on lab work and tests. I am responsible for any charges beyond that of the flat office visit fee, should any accrue.

_____ I am responsible as the patient or patient's guarantor for **full payment of services rendered at time of service** (unless payment arrangements have been made), including Medicinary, lab work and tests, and physician ordered add-on lab work and tests.

_____ I am responsible as the patient or patient's guarantor to contact my insurance provider to learn my coverage benefits. I acknowledge I have access to Northwest Integrative Medicine's Insurance Verification & Information Form provided for my convenience through the patient portal. I acknowledge that if an insurance company has given me inaccurate information, they may not honor the benefits that were quoted.

_____ I understand that insurance billing is provided as a courtesy, and that I am responsible for all claims unpaid by my insurance company. I agree to be billed for any amount not paid by my insurance, and will submit payment to my physician within 30 days of receiving a bill.

_____ I acknowledge that **if my provider is out-of-network** for my insurance provider, my insurance provider may or may not reimburse my office visit fee, paid at time of service.

_____ I acknowledge **my insurance provider may or may not cover** the cost of the office visit fee and does not typically cover the cost of any natural medicine products.

_____ I am responsible for providing all accurate and thorough documentation required to support any discounts I am receiving.

_____ Financial options are extended to me based on the information I have provided.

_____ I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize Northwest Integrative Medicine to release information necessary to secure payment.

_____ _____
Sign Name Patient (18yr or older) Date

_____
Print Name

_____ _____
Sign Parent, Guardian, Responsible Party Print Name Parent, Guardian, Responsible Party

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