In Health Naturopathic Medicine - Crystal Hannan, ND
4150 Pacific Avenue, #300 - Forest Grove, OR 97116
Ph 503.357.3074 www.inhealthclinic.com

FINANCIAL RESPONSIBILITY AGREEMENT

Please take the time to read and sign the financial responsibility statements to acknowledge your understanding of them. These are intended to provide you with clear understanding of our financial agreements and billing procedures to prevent misunderstandings. If you have any questions regarding these agreements, please let the staff or your practitioner know.

ALL CO-PAYMENTS, CO-PERCENTAGE PAYMENTS, COSTS OF ALL SUPPLEMENTS AND COSTS OF SERVICES NOT COVERED BY YOUR INSURANCE COMPANY ARE DUE AND PAYABLE AT THE TIME OF EACH VISIT.

If you have insurance that may cover alternative health care, it is your responsibility to fill out the insurance details form and provide your insurance card to the front desk to bill your insurance carrier completely and accurately. We request that you confirm benefits with your insurance company prior to your first office visit. When possible, we will call to verify your insurance coverage before the end of your appointment. If benefits cannot be determined at the time of service, and/or when there is any doubt, payment in full is expected. (For your convenience, we accept the following types of payment: cash, check, Visa & MasterCard.)

Please initial here _____

Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. As a service to you and upon your request we can bill your insurance provider. We ask that you stay involved with the billing process. There are normal and expected times that we will need to re-bill your insurance company. However, if there becomes a time when the costs of completing your billing are over and above the usual and customary time spent to process and follow-up on a claim, we will contact you. If you would like us to continue to pursue billing your insurance company, you will be charged $12.00 for the additional time spent on the claim, in order to help defray costs of completing the payment for you.

Please initial here _____

Any balances due to us after your insurance carrier has notified us of payment or non-payment will be billed to you. After thirty (30) days of the first bill, a finance charge will begin to apply to the account. Any bill over ninety (90) days past due will be subject to collection procedures. If you need to make payment arrangements, you can do so by signing and agreeing to a payment plan at the time of service. All payment agreements must be followed through within the above timeline. We reserve the right to agree, or not, to payment plans, as they are not a guaranteed service of our clinic.

Please initial here _____

Upon receipt of payment from your insurance company, your account will be credited. Any amounts due will remain on your account as a credit for your use towards future services and/or purchases. If you would like to be issued a refund, please let us know and we will be happy to send you a check.

Please initial here _____

If you do not have insurance that covers services provided at this clinic, payment in full is expected at the time of service. If you need to make payment arrangements, you can do so by signing and agreeing to a payment plan at the time of service. All payment agreements must be followed through within the above timeline. We reserve the right to agree, or not, to payment plans, as they are not a guaranteed service of our clinic. After thirty (30) days of the first bill, a finance charge will begin to apply to the account. Any bill over ninety (90) days past due will be subject to collection procedures.

Please initial here _____

You are financially responsible for the cost of supplements, at payment is due at the time of purchase. There are only a few known insurance companies that cover these. Where applicable, consider using your MSA/FSA for the purchase of supplements. We can supply you with an itemized receipt to provide proof of purchase.

Please initial here _____

Please note there are some alternative health care insurance plans that require special forms. You may have additional forms to sign at each visit if you are on one of those plans.

Please initial here _____

There will be a $50.00 charge for all no-show and/or appointment cancellations with less than 24 hours notice.

Please initial here _____

You may be charged for phone conversations with your doctor that exceed 10 minutes. Generally, these calls cannot be billed to insurance. If you have a matter that is more extensive and you rely on insurance, please make an appointment.

Please initial here _____

I, _____ (patient's name), a patient of the above indicated physician, acknowledge and agree to the above statements and understand that a part or all of my care may not be a covered benefit of my health plan. I acknowledge and agree to be financially responsible for my treatment.

_____ _____

Patient / Responsible Party Signature Date

_____

Patient / Responsible Party Printed Name