Madeleine Morrison N.D.

PAYMENT FOR SERVICES
Please read, initial where indicated and sign below:

PATIENT RESPONSIBILITY:

- Insurance is not a guarantee of payment (_____ initial)
- We will bill your insurance if you present your insurance card(s) at the time of your appointment. It is important for you to know that we are not always contracted with your insurance carrier. This means that you are responsible for monitoring the processes of your insurance company to make certain your claim is processed in a timely manner, for contacting them if you have questions as to how your claim was processed, and that you are ultimately responsible for payment of services rendered. (_____ initial)
- Any co-payments or "patient responsibility" percentages must be paid at the time of service. (_____ initial)
- If we do not receive a response from your insurance company within 45 days from the date we bill them, the balance will become your responsibility. (_____ initial)
- You will receive a statement for any remaining balance after all applicable insurances have been applied. That balance is due in full at that time. (_____ initial)
- If we do not receive your payment in full within 90 days from the date of the first statement or have not heard from you about setting up a payment plan, your account may be turned over to a third-party collection agency. (_____ initial)

We also recommend that **you research your insurance benefits** prior to your office visit, there could be reasons your insurance will not pay for your visit. This may be due to your deductible not having been met, or the services provided not being covered by your policy. Injections and dispensary items are NOT covered by insurance and must be paid in full at the time of your visit.

We accept cash, checks, and all major credit cards. If a payment in check form is returned to us because of insufficient funds, you will be charged a $40 fee. Payment in full at the time of service is required in the following circumstances.

- You do not have the insurance coverage
- You have not brought your insurance cards with you
- You have not met your deductible
- A contract is required by your policy and we are not contracted with your insurance carrier
- Any procedures or treatments we believe are not covered by insurance

By signing below, you acknowledge that you have read and understand the above statements and are willing to accept responsibility for services rendered if not covered by insurance. You also understand that you are responsible for laboratory charges not covered by insurance. This authorization is not limited in time.

Patient Signature (or responsible party) Date _____

_____