THE WOMEN & CHILDREN'S NATURAL HEALTH CENTER

PATIENT AGREEMENT

CURRENT INSURANCE CARD/ PHOTO ID: All patients must present a current insurance AND valid photo identification card (state issued driver's license or identification card) to be scanned into the patient medical record. If the patient being treated is a minor, the parent or guardian financially responsible must present their card and photo identification. **If a valid insurance card is not presented before your visit, payment is due in full when the service is provided. Please notify us at the time of your visit of any changes in your insurance charge.**

APPOINTMENTS: 24 hours notice must be provided in the event you cannot keep an appointment. Should you not provide this notice, a cancellation fee may then be added to your account. The fee charged for missing the **first** office visit is $65, and subsequent missed visits a full office charge will be billed directly to the patient or guarantor.

REFERRALS: If your plan requires a referral from your primary care physician, it is **YOUR** responsibility to obtain it prior to your appointment and have it with you at the time of your visit. If you do not have a referral, you will be required to pay for the visit.

PATIENT CHARTS: Inactive patient charts will be shredded after 7 years.

PAYMENT POLICIES

Insurance is a contract between you and your insurance company. We are not a party to this contract. We are not responsible for or in control of what services your insurance company will pay for or the amount your insurance company will reimburse for services rendered.

CO-PAYMENTS: By contract, we **MUST** collect your insurance carrier designated co-pay. This payment is expected at the time of service. Please be prepared to pay the co-pay at each visit.

CO-INSURANCE AND DEDUCTIBLES: You are responsible for the payment of any amount that your insurance carrier deems to be co-insurance or deductible. Due to our contractual obligations with your insurance company, we are not able to write off co-insurance and deductibles. We do not bill secondary insurance.

ACCOUNT BALANCES: All balances billed to you are due within 30 days of the bill date. If you choose to delay payment, you will incur interest on the account. Accounts that are 90 days past due will be turned over to a collection agency. All balances must be paid before your visit with the doctor.

SELF-PAY PATIENS: Payment is expected at the time of service. Payment may be made by cash, check or credit card. We accept Visa and Master Card.

NSF CHARGE: $45 will be charged if a personal check is returned due to "insufficient funds" and a different form of payment will be expected for past balances and future services rendered.

PHARMACY: Once purchased, pharmacy cannot be returned or refunded.

DIVORCED/ SEPERATED PARENTS OF MINOR PATIENTS: The parent who brings the minor child to the physician is responsible for payment of services rendered. The Women & Children's Natural Health Center will not be involved with separation or divorce disputes.

Patient Name: ______________________________ **Guardian Name:** _________________________________

Signature: ____ **Date:** _____________________________

Please turn page over to continue.

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Registration Form

Date ___________________________ (PLEASE PRINT) Home Phone_____________________________

Patient Information

Name ____ Soc. Sec. # _________________________

Last Name First Name Initial

Address ____

City ____ State _______________ Zip _____________________________

Sex ☐ M ☐ F Age __________ Birthdate _________________ ☐Single ☐Married ☐Widowed ☐Separated ☐Divorced

Patient Employed by____ Occupation ____________________________________

Business Address ____ Business Phone _______________________________

Whom may we thank for referring you? ____

In case of emergency who should be notified? ________________________________ Phone ________________________________

Primary Insurance

Person Responsible for Account ____

Last Name First Name Initial

Relation to Patient ____________________________________ Birthdate ___________________ Soc. Sec. # ___________________

Address (if different from patient's) ____ Phone _______________________

City ____ State _______________________ Zip ___________________________

Person Responsible Employed by ____ Occupation __________________________

Business Address ____ Business Phone ____________________________

Insurance Company ____

Contract # ______________________________ Group # ______________________ Subscriber # _____________________________

Names of other dependents covered under this plan ____

Assignment and Release

I, the undersigned certify that I (or my dependent) have insurance coverage with ____

Name of Insurance Company

and assign directly to Dr. Demanski all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

____ ______________________________ _______________________

Responsible Party Signature Relationship Date