INTENTIONAL HEALTH CLINIC
1785 NE Sandy Blvd., Suite 290, Portland, OR 97232

Financial Responsibility

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

- ✓ I understand that if I do not give adequate cancellation notice or miss appointment entirely, I will be charged a missed appointment fee of $50. This is regardless of any discounts I am receiving. Clinic requires a minimum of 48 hours' notice to cancel or reschedule an appointment. Insurance cannot be billed for missed appointments and therefore I understand that I am responsible for the charges in full.
- ✓ I understand that the office visit fees for new or returning patients do 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 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 healthcare provider within 30 days of receiving a bill.
- ✓ I acknowledge that if **my provider is out-of-network** for my insurance provider, my insurance 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 Intentional Health Clinic 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