Balanced Wellness Primary Care

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Consent For Treatment and Financial Responsibility

Please read and initial each item:

_____If I have medical benefits, I will bring my valid insurance card with me to my visit. It is my responsibility to keep the practice informed of any changes to my coverage/benefits. I am aware I will be expected to pay my copay and any out of pocket expenses such as non-covered services (if I choose to have them performed), co-insurance and or/deductible at time of service.

_____I understand Balanced Wellness Primary Care, LLC participates with multiple insurance companies. The practice will submit my claim to my insurance. I authorize payment of medical claims to be made directly to the practice. I permit a copy of this authorization to be used in place of the original. As a courtesy, this office may agree to submit claims to my insurance even if we are non-participating with my plan. If Balanced Wellness Primary Care, LLC is non-participating with my plan, I understand that this office is not obligated to accept my insurance payment as full payment and I may receive a bill for the unpaid balance.

_____If necessary, collection fees are added to delinquent accounts. I understand that I am responsible for any collection fees incurred on my account.

_____I understand a service charge of $25.00 will be charged to me if my check is returned for non-payment.

_____I understand that it will be necessary for me to give a minimum 24 notice when cancelling an appointment. Repeated failure to comply will result in my being discharged from the practice.

_____Permission is given to Balanced Wellness Primary Care, LLC and employees to perform routine diagnostic procedures, physical examinations, and to administer whatever routine treatment and/or services are deemed necessary for the diagnosis and treatment of my condition(s).

PATIENT NAME:_____DATE:_____

SIGNATURE OF PATIENT (OR PARENT/GUARDIAN):

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