Patient Name_____ **Date of Birth**_____

Natura Medica

12 Roosevelt Avenue Mystic CT 06355 Tel 860 572-9566 Fax 860 572-7318 www.naturamedicamystic.com

PATIENT FINANCIAL RESPONSIBILITY

1. Individual's Financial Responsibility

- I understand that I am financially responsible for my health insurance deductible, coinsurance (copayment) and/ or non-covered service. _____ (Patient/ Guarantor Initials)
- Co-payments are due at time of service. _____ (Patient/ Guarantor Initials)
- In the event that my health plan determines a service to be "not payable, " I will be responsible for the complete charge and I agree to pay the cost of all services provided. _____ (Patient/ Guarantor Initials)
- If I have a deductible, I understand that I will be responsible to pay the "allowable charge" and I agree to pay such charges. _____ (Patient/ Guarantor Initials)
- I understand that it is my responsibility to provide all accurate and updated insurance information. (Including front and back copies of insurance card and photo I.D.) _____ (Patient/ Guarantor Initials
- In any event I cannot pay my bill in full, I will put in place a payment schedule with the office._____ (Patient/ Guarantor Initials)
- I understand that if I do not pay my bill after 60 days an interest fee of 0.83% will be applied monthly. _____(Patient/ Guarantor Initials)
- I understand that if I do not pay my bill after 120 days, I will be sent to collections._____ (Patient/ Guarantor Initials)
- If I am uninsured, I agree to pay for the medical services rendered to me at time of service. _____ (Patient/ Guarantor Initials)
- I understand that if I arrive at least 15 minutes late, do not cancel a minimum of 24hours prior to or/ do not show for my scheduled appointment I will be charged $60.00 and I am personally responsible for this fee. I will be responsible for rescheduling my appointment _____ (Patient/ Guarantor Initials)
- If my check/payment bounces, I understand I will be responsible for all banks fees incurred _____ (Patient/ Guarantor Initials)

2. Insurance Authorization for Assignment of Benefits

I hereby authorize and direct payment of my medical benefits to Integrative Wellness Center, LLC dba Natura Medica on my behalf for any services furnished to me by the providers.

3. Authorization to Release Records

I hereby authorize Integrative Wellness Center, LLC dba Natura Medica to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization, or referral to other medical provider.

_____ _____

Signature of Patient, Authorized Representative or Responsible Party Date

Printed Name _____ Relationship to Patient_____

☐ Patient requests copy ☐Patient deferred copy