NATURA MEDICA
12 Roosevelt Ave Mystic CT 06355
860-572-9566

PATIENT 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 I have a deductible, I understand that I will be responsible to pay the "allowable charge" and I agree to pay such charges by one of the following options 1) prepayment (due at time of service)_____ 2) credit card on file _____ (see Financial policy page 2) (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 am uninsured, or my insurance does not cover Naturopathic Medical care (SELF PAY) I agree to pay at time of service for the medical services rendered to me. _____ (Patient/ Guarantor Initials)
- **I understand that if I 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** _____ (Patient/ Guarantor Initials)
- In any event I cannot pay my bill in full, I will put in place a payment plan 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 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