BRANNICK CLINIC
of Natural Medicine
WHOLE HEALTH PRIMARY CARE & WELLNESS

Clinic Policies

Patient Name: _____ Date of Birth: _____

Release of Information
All information provided herein is true and correct; I hereby consent to treatment. I give permission to my provider and staff to release information, verbal and written, contained in my medical record and other related information ONLY to related healthcare providers, assignees, and/or beneficiaries and other related persons. I have read and understood this release.

Insurance and Bill Payment Information:

1. **Payment is your responsibility:** Knowledge of your insurance policy is very important! We will take a copy of your insurance card when you first come into our office. If there are any changes with your insurance coverage, or if you switch insurance companies, please notify our office. We will submit your insurance claim for you. ***You, however, are responsible to determine whether services provided or to be provided are covered by your insurance.*** Once your claim is submitted to insurance, we are ***unable to change billing or coding to help you get coverage,*** so you need to let the doctor know ***ahead of time*** about a high deductible or no coverage for preventive care services. In any event, you are also responsible for your bill, including any deductible and/or copay, and you must pay any balance not covered by insurance within 30 days of billing. Payment is due at the time of service.
2. **Balance to be paid** with 30 days of billing invoice date sent to you. You may call our office and pay with your credit card (we accept Visa MC AmEx & Discover), or you may send a check.
3. **Unpaid Account:** If payment is not obtainable by credit card or check at the time of services, we will charge you 9% interest on any unpaid balance. Any check returned unpaid will be subject to a $30.00 fee. In the event your account must be sent to collection, you will be responsible for any costs and attorney's fees incurred as a result of any collection action taken.
4. **Missed Appointments:** In the event you cannot make an appointment, please give 24 hours notice. (You may leave messages on our phone recording after hours). If you fail to notify us of your intention to miss an appointment, you authorize us to charge your account $50.00/per 30 minutes. You understand that repeatedly missing appointments will cause us to terminate you as a patient. This fee is in addition to and exclusive from any insurance coverage you may have, weather public or private. This fee will be subject to the collection procedures outlined above.

I understand the terms of payment to the office Brannick Clinic of Natural Medicine. I authorize payment of medical benefits to my physician. I also consent to the performance of any office procedure or treatment that may be necessary to make an appropriate diagnosis.

Credit Card of file:

I authorize Brannick Clinic of Natural Medicine to charge outstanding patient portion balances, supplements and cancellation fees for my dependents and myself to the following credit card.

Credit Card Number _____/_____/_____/_____

Expiration Date _____/_____ Code: _____

Address _____

State: _____ Zip Code: _____

I acknowledge that I have read and understood the above information and the authorization to apply balance to my credit card listed above.

Date: _____ Patient or Guardian Signature: _____

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Printed Patient Name: _____

FINANCIAL POLICY

Patient Name: _____ Date of Birth: _____

IF YOU DO NOT HAVE INSURANCE: All payments are expected at the time of service.

FOR PATIENTS WITH INSURANCE: All deductibles and copayments are expected at the time of service or by a mutually agreeable payment plan. We bill most insurance carriers for you if proper paperwork is provided to us. We will also bill most secondary companies for you. Copayments and deductibles are due at the time of service. Since your agreement with your insurance carrier is a private one, we do not routinely research why an insurance carrier has not paid or why it paid less than anticipated for care. If an insurance carrier has not paid within 60 days of billing, professional fees are due and payable in full from you. Your personal balance may not exceed $150.00 at anytime or care may be suspended.

Our fees are considered usual, customary, and reasonable by most companies, and therefore are covered up to the maximum allowance determined by each carrier. This statement does not apply to companies who reimburse based on an arbitrary schedule of fees bearing no relationship to the current standard of care in this area.

Please check one: I have paid my insurance deductible for the calendar year _____. ☐Yes ☐No ☐Don't know

NON-COVERED SERVICES: Any care not paid for by your existing insurance coverage will require payment in full at the time services are provided or upon notice of insurance claim denial.

PERSONAL INJURY CASES: This office does not bill for third party auto accident or other liability or lawsuit-related cases. You are responsible for payment at the time of service. We do not accept liens. We will however bill your medical payment portion of your personal auto insurance or your major medical insurance carrier for services related to your personal injury case.

WORKER'S COMPENSATION: If your injury is work-related, we will need the case number and carrier name prior to your visits in order to bill the worker's compensation insurance company.

ASSIGNMENT OF INSURANCE BENEFITS: Patients with insurances, please read and sign below.
I hereby assign all medical benefits, to include major medical benefits to which I am entitled, private insurance, and any other health plans to Brannick Clinic of Natural Medicine. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as an original. I understand I am financially responsible for all charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure the payment.

Signature: _____ Date: _____

If you discontinue care for any reason other than discharge by your provider, all outstanding balances will become immediately due and payable in full by you.

If a payment is returned by your bank or creditor unpaid for any reason, we reserve the right to automatically withdraw that payment in-full by electronic funds transfer from that account or the credit account we have on file, along with an additional fee of $30.00. Any and all financial information provided by you will be protected as part of your Personal Health Information and additionally protected under federal HIPAA regulation and therefore subject to a $10,000 fine to anyone who misuses this information.

I have read, understood, and agreed to the above financial policy for payment of professional fees.
The patient is ultimately responsible for all professional fees.

Signature: _____Date: _____