Anderson Integrative Medicine, PLLC
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CONSENT AND FINANCIAL POLICY

Consent for Treatment: By signing this form, I am giving my permission for Anderson Integrative Medicine to treat me, including the performance of testing and/or procedures, as deemed necessary and appropriate in the exercise of the provider's professional judgment.

Payment for Service: The Practice accepts most major private health plans, as well as Medicare. I understand I am responsible for paying the full amount for all services on the day of service, unless the Practice has an agreement with my insurance carrier. If I am insured, I authorize the Practice to release all information necessary to secure payment. I further understand my share of the cost of the services, e.g., co-payments, co-insurance, and deductibles, will be collected upon check-out.

Insurance Claims: As a courtesy, the Practice will file insurance claims with your insurance carrier. Your insurance company, in lieu of reimbursing you directly, will typically pay the Practice any benefits for services rendered. Your insurance carrier may pay less than the actual bill for services, so you may be responsible for payment of all services rendered. You are responsible for making available complete insurance information for accurate filing of claims. To meet this end, we will request your current insurance card at each visit. Reduction or rejection of your claim by your insurance company does not relieve the financial obligation you have incurred. It is your responsibility to know and understand your medical insurance coverage. Not all services are a covered benefit in all contracts. Additionally, some services we provide will be billed separately for the office visit and may require a separate co-pay or be applied to your co-insurance/deductible. Please call your insurance company to verify your benefits. You will be responsible for all fees not paid by your insurance company

For those who do not have health insurance, payment for services rendered is required at the time of service.

Workers Compensation/Accident Cases: In order for the Practice to file a claim with workers' compensation or other liability carrier, you must provide complete billing information. Without this information we are unable to bill your insurance carrier and we will ask for payment in full at the time of service. Patients shall be financially responsible for medical services related to work comp/accident if insurance fails to pay in full. We do not bill attorneys for medical services.

Unpaid Account Balances: In the event that you fail to make payments for services rendered, your account may be turned over to a collection agency. You will be responsible to pay the collection agency's fees that may be incurred in the collection of any outstanding balance.

By signing below, I agree to the terms set forth above.

______________________________ ______________________
Parent or Guardian Signature Date

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Print name