PATIENT INSURANCE INFORMATION:

THHC will bill your insurance carrier if proper coverage verification is received. Please complete the required insurance information and acknowledgement fields below, as well as the Insurance and Financial Policies page attached. Please include **a front & back copy of your primary insurance card to the front desk**.

NOTE: We bill primary insurance only. We are unable to bill Medicare/Medicaid.

I. Patient Name:_____

Address:_____

City:_____ State:_____ Zip:_____

Preferred Phone #:_____ Additional Phone #:_____

Name of Employer: _____ Address: _____

Patient's: Date of Birth (*required*) / / Social Security # (*required*) _____

*Would you like to receive our newsletters? E-mail: _____

All information is private, will not be sold and has the ability to unsubscribe

II. Insured Name (***required if different than patient***):_____

Address:_____

City:_____ State:_____ Zip:_____

Day Phone #:_____ Eve Phone #:_____ **Relationship to Patient:** _____

Employer of Insured (***required if different than patient***) _____

Insured's: Date of Birth (*required*) / / Social Security # (*required*)_____

III. Name of Insurance Company:_____

Claims Address:_____

City:_____ State:_____ Zip:_____

Phone #:_____ Group or Policy #:_____ ID#:_____

PATIENT RESPONSIBILITY ACKNOWLEDGEMENT & ASSIGNMENT AUTHORIZATION:

1) I understand that I am financially responsible for all charges not paid by my insurance, with ***payment expected from me within 30 days of statement notification***. I understand that non-compliance with payment terms can immediately result in my forfeiture of any and all insurance billing options extended to me by THHC.

2) I authorize release of information in my medical history to my insurance company and assign all benefits for unpaid services to my doctor at THHC. A photo static copy of this authorization shall be considered as effective as the original. Assignment will remain in effect until revoked by me in writing.

Patient Signature:_____Date:_____

Insurance and Financial Policies Tigard Holistic Health Clinic:

1)**Insurance:** _____**Initial**

Some providers participate or contract with certain insurance companies. If we do not participate with your particular insurance company at this time, we may still be able to bill as an out-of-network provider. Knowing your insurance coverage is your responsibility – please contact them with questions about your coverage before your visit.
In some cases, care agreed to be medically indicated by the physician and the patient **may not be covered** by insurance (for example: laboratory work-up, annual exams, pre-existing conditions, IV Therapy) and you will be required to pay for these services. Please check with your insurance company to find out if there are any exclusions in your individual policy. **It is important to understand that a verbal confirmation of coverage over the phone from the insurance company does not guarantee payment by them.** As is not uncommon for an insurance company to misquote a policy, we recommend reviewing your policy to confirm that the information we received is correct. It is the patient's responsibility to follow up if a claim is not paid. **Please be aware that you are responsible for the balance of your claim as decreed by your insurance company.**

2)**Co-Payments and Deductibles:** _____**Initial**

By signing this agreement you agree to pay your co-payment, co-insurance and/or deductible and any fees that your insurance company does not cover. Co-payment or co-insurance is an arrangement between you and your insurance company. Failure on our part to collect co-payments, co-insurance and deductibles from patients could be considered fraud. Please be informed about your co-payment, co-insurance and deductible.

3)**Proof of Insurance:** _____**Initial**

All patients with insurance coverage must complete the patient intake forms and provide a current valid insurance card. This card will be copied and stored with your patient chart. If insurance coverage changes or expires, please provide a current card as soon as it is issued.

4) **If you do not have insurance, payment in full is expected at the time of services rendered**. _____**Initial**

5)**Supplements and IV Therapy** _____**Initial**

Supplements and IV Therapy are not covered by insurance companies. Payment in full is expected at the time of purchase. We are prohibited from accepting returns once a safety seal has been broken. There is no requirement to purchase recommended supplements from our office. There are several stores locally that may carry similar products.

6)**Non-Payment:** _____**Initial**

If your account is over 90 days past due, you will receive a letter stating that you have 30 days to pay your account in full. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, your account may be referred to a collection agency and charged a processing fee of $75 and you and your immediate family members may be discharged from this practice. If this is to occur, you will be notified by regular and certified mail that you have 30 days to find alternative medical care. During that 30 day period, our physician will only be able to treat you on an emergency basis. It is your responsibility for all fees incurred to obtain payment.
There is a $35.00 fee for returned checks to cover bank fees.

7)**Late Cancellations/Missed Appointments:** _____**Initial**

As a courtesy to other patients requiring services, we request that you provide notice of cancellation 24 hours in advance of your appointment. **Patients who do not give 24 hours notice for a missed appointment will be charged a fee of $35.00.** After two missed appointments, you will be charged for the entire time reserved for you on the schedule. Exceptions are made for emergency/serious cases.

Authorization:

- I have read the above 2 pages of information and agree regardless of my insurance status to be responsible for the balance of my account. I agree to pay for all services rendered not covered by my insurance and to notify this office should there be any changes to my insurance coverage.

AND

- I authorize the release of any medical or other information necessary to process any claims.

AND

- I authorize payment of medical benefits to my THHC physician/provider _____ .

Name (please print): _____ **Signature:** _____ **Date:** _____