

WELLNESS RESOURCE MEDICAL CLINIC
ALLERGY AND ENVIRONMENTAL MEDICINE

FINANCIAL POLICY AND PATIENT PRIVACY AGREEMENT

We welcome you to Wellness Resource. We are able to concentrate on the practice of environmental medicine and provide quality care by having our financial policies and privacy practices understood by our patients and thereby avoid confusion or misunderstanding.

Financial Policies

As a courtesy to our patients, we will bill insurance claims with a maximum of two insurance carriers per patient. While filing insurance claims is a courtesy extended to our patients, it is not a guarantee of payment. You will be billed directly for the services rendered if your insurance carrier has not paid us within 30 business days. All monies owed by the patient (e.g. co-payments, deductibles, required "out of pocket" amounts, non-covered services and co-insurance amounts) are due at the time services are rendered.

For patients without insurance coverage or insurance plans with whom we are not contracted (i.e. out of network coverage), we require payment at the time services are rendered.

It is your responsibility to know and understand your insurance policy. If your account is placed with a collection agency due to non-payment, you will be responsible for any additional charges that may be incurred, including collection agency fees, attorney fees, court fees, and any other fees associated in collecting the balance due.

We accept cash, check, Visa or Mastercard. There will be a \$20.00 charge for each check that is returned for insufficient funds.

PATIENT

SIGNATURE: _____ DATE: _____

Health Information Privacy and Accountability Act (HIPAA agreement)

The undersigned is aware of the Notice of Privacy Practices provided by the Wellness Resource Medical Clinic which describes how medical information about patients may be used and disclosed and how you can get access to this information.

Because of the nature and specialized tools and training required for allergy therapy, testing often occurs in a semi-private setting with other patients in the room. The undersigned is aware and agrees to allergy testing which occurs in a semi-private setting.

PATIENT

SIGNATURE: _____ DATE: _____

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