Patient Responsibility Agreement

Cancellation - Circumstances arise for all of us that may prevent you from keeping your appointment. We recognize this fact, but we respectfully request that you cancel your scheduled appointment by phone a minimum of 24 hours in advance. This way your slot may be filled by another patient needing an appointment. If you do not cancel by the deadline, you will be assessed a $15.00 fee. This fee is not covered by insurance or Medicare and it will be your responsibility. Occasionally, emergencies arise; they will certainly be taken into consideration. Please call the office and talk directly with the doctor if you feel your situation meets these criteria.

No Show - If you do not call and cancel your appointment and do not show up for it, you will be assessed a $25.00 no show fee. This fee is not covered by insurance or Medicare and it will be your responsibility. Occasionally, emergencies arise; they will certainly be taken into consideration. Please call the office and talk directly with the doctor if you feel your situation meets these criteria.

Past- Due Accounts - It is your responsibility to keep your account current with Natural Pain Management and Wellness. A $15.00 billing fee will be attached to all accounts that must be rebilled. Furthermore, if your account remains unpaid, it will be flagged. This means you will not be able to schedule your next appointment until arrangements have been made to clear the outstanding balance. Any account that remains unpaid past 30 days will accrue interest at the rate of 8% per annum.

Collections - If you fail to make payment when due, Natural Pain Management and Wellness reserves the right to refer your account to a third party for collection. You will be responsible for all costs associated with the collection, including attorneys' fees.

FINANCIAL/PATIENT RESPONSIBILITY - I have read the above agreement and understand and accept the terms of patient responsibility. I understand that I am responsible for fees that can be attached if I do not keep my appointment. I also understand that, in the case of non-payment, I will be responsible for any and all collection fees and/or attorneys' fees.

_____ _____

Signature of Patient or Personal Representative Date

_____

Printed Name of Patient or Personal Representative

_____ _____

Witness Date