CROSSROADS HOLISTIC HEALTH CENTER

Office Policies

In order to receive treatment, all patients must agree to and sign the listed policies:

Initials

_____ PAYMENT: Patients are responsible for payment at 'time of service' - upon receipt of all supplements, supplies and office visits. Where specifically agreed by the Doctors, payment plan arrangements may be made with the office. The current interest rate is 8.75%.

_____ UNPAID BALANCES: Unless arrangements have been specifically made all balances unpaid for longer than 30 days will accrue interest at the rate of 8.75%.

_____ HEALTH INSURANCE: Patients who have insurance coverage bill their own carrier for reimbursement. Patient pays in full at the time of service. Crossroads Holistic Health Center will provide the billing statements and documentation to the Patient to process their own personal billing with their insurance company.

_____ PERSONAL INJURY: Crossroads Holistic Health Center may agree to bill med pay or insurance carriers directly in the case of an auto or personal injury. Before accepting liens of any kind, the case will be discussed with the insurance company and/or the appointed attorney. Patient is fully responsible for the entire bill regardless of the monetary settlement agreement decided by the attorney and patient, or attorney and appointed guardian of patient.

_____ MISSED APPOINTMENTS: Patients will be charged the full dollar amount of the services to be provided at the office visit for failure to give 24-hour cancellation notice.

_____ CURRENT CONTACT DETAILS: Patient/guardian is responsible for keeping current all patient contact details – name, address, telephone number and email.

_____ PRIVACY PRACTICES: I have read a current copy of Crossroads Holistic Health Center Privacy Practices and Regulations. I understand and agree. If I wish to revise any policies or privacy practices pertaining to my record I will do so in writing.

_____ RESPONSIBILITY FOR PAYMENT: I understand and agree that all services rendered are charged directly to me and that I am responsible for payment and the entire bill accrued. I also understand that if I suspend or terminate care any fees owed by me will be due immediately. If my account goes to collections for any reason I understand I am responsible for all legal/collection fees incurred.

_____ CONSENT TO TREATMENT: By signing this I agree to all of the above policies as well as give consent and authorize treatment for myself and/or listed minor.

Signature____________________________________Print Name:________________________________Date:________

PLEASE HELP US BETTER SERVE OUR COMMUNITY BY KEEPING ALL SCHEDULED APPOINTMENTS