NATURAL HEALTH CLINIC
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FINANCIAL AGREEMENT FOR PATIENTS WITH INSURANCE

I, ______________________________________, being a patient of The Natural Health Clinic, do hereby acknowledge that my health insurance policy is an arrangement between the insurance company and myself.

I understand that it is my responsibility to know and understand my insurance policy, its requirements and its benefits.

I understand that certain services may not be covered by my insurance under the terms of my policy. I understand that I am responsible for all bills incurred at this office and I agree to make financial arrangements with my practitioner to pay for any services not covered by my insurance policy. I understand that pharmacy costs are almost never covered by any insurance company, and I am therefore aware that payment for pharmacy is due at the time of purchase.

Although my insurance billing is my responsibility, I understand that as a courtesy, The Natural Health Clinic is willing to pursue collection for services from my insurance company on my behalf. I understand that re-billing and any appeals processes are my responsibility. If attempts to collect from insurance companies for services rendered have been unsuccessful, it is my responsibility to pay The Natural Health Clinic within 3 months of the date of service.

I authorize payment of all medical benefits to be made directly to The Natural Health Clinic

Insurance Plan: ____
Insured's Name: ____
Insured's I.D. Number: ____
Policy or Group number: ____

X____ _______________
Patient Signature Date