2146 NE 4TH Street #160 Bend, OR 97701
541-306-4471 phone | 541-566-7493 fax
ElixirBend.com

FINANCIAL POLICY

Please **initial and sign** to acknowledge that you have read and understand the clinic's financial policy.

____ I acknowledge that, if I do not provide 24 hours notice to cancel an appointment I will be *charged a* **missed appointment fee of $45**. Emergencies will be taken into consideration.
____ I acknowledge the office visit fees do not include supplements or lab work. I am responsible for any charges beyond that of the flat office visit fee, should any accrue.
____ I am responsible as the patient or patient's guarantor for full payment of services rendered at time of service, including supplements and lab work.
____ I am responsible as the patient or patient's guarantor to contact my insurance provider to learn my coverage benefits. Insurance benefits will be verified as a courtesy in office as well. I acknowledge that if an insurance company has given inaccurate information, they may not honor the benefits that were quoted.
____ I understand that insurance billing is provided as a courtesy and that I am responsible for all claims unpaid by my insurance company. I agree to be billed for any amount not paid by my insurance and will submit payment to my provider within 30 days of receiving a bill.
____ I understand that copays and other estimated out of pocket amounts due are to be collected at the time of service.
____ I acknowledge that, **if my provider is out-of-network** for my insurance carrier, my insurance carrier may or may not reimburse my office visit fee, paid at time of service. I understand that Elixir does not bill out of network benefits. A discount of 30% will be extended for time of service payments.
____ I acknowledge **my insurance provider may or may not cover** the cost of the office visit fee or procedures and does not typically cover the cost of any natural medicine products.
____ I understand that there will be a $35 fee for all returned checks and for stop payments.
____ I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize Elixir: A Wellness Collective to release information necessary to secure payment.

By signing below you state that you have read and understand the above financial policy and agree to abide by the terms afore mentioned.

_____ _____
SIGNATURE OF PATIENT / GUARDIAN PRINT PATIENT'S NAME

_____ _____
PRINT NAME OF LEGAL GUARDIAN DATE