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

# OFFICE POLICIES

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

____ Fees are dependent on complexity of care needed and any services provided. A 30% discount is applied if you pay at time of visit. Payment for non-covered services and insurance copayments are due at time of service. We accept cash, HSA benefits, credit cards, checks and cash. Office visit fees do not apply to supplements or lab work.

____ Our providers are in-network with a limited number of insurance companies. I understand that Elixir does not bill out of network benefits. If your provider is out-of-network for your insurance provider, your insurance provider may or may not reimburse your office visit fee, paid at time of service. Your insurance company does not typically cover the cost of any natural medicine products. Please contact your insurance company to ensure your coverage.

____ We require a 24-hour advance notice of cancellations or re-schedules. Please call the office to notify us of this. If office staff are not available, you may leave a message on the confidential voice mail. If you do not give adequate notice you will be charged a missed appointment fee of $45, This fee is not covered by insurance and is due prior to any next appointment.

____ If you arrive more than five minutes late to an appointment, you may be asked to reschedule.

____ Elixir requires 2 business days to respond to all medication refill requests. It is recommended that you contact your pharmacy to initiate refill requests at least one week prior to running out of your current prescription to prevent any lapses in medication availability.

____ Once purchased, supplements cannot be returned. This applies to any product, open or un-opened. Please let us know if you are on a budget and we will gladly prioritize your treatment options or look for less costly alternatives.

I acknowledge I have been provided with, read, understand, and agree to the office policies as written above.

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

_____ _____
PRINT NAME OF LEGAL GUARDIAN DATE