RĒBALANCE, A NATUROPATHIC CLINIC

Helping active people take control of their health

AUTHORIZATION & ACKNOWLEDGEMENTS
☐ INITIAL ☐ ANNUAL UPDATE

TREATMENT AUTHORIZATION: I (print name) _____ authorize medical treatment of myself or my minor child by physicians, nurse practitioners, medical assistants and staff at **Rēbalance.**

NOTICE AS TO NATURE OF SERVICES: I understand that the care I receive at **Rēbalance m**ay be nontraditional or unconventional. Such services are commonly referred to as complementary or alternative or holistic medicine, or innovative services. Many of these services may not be recognized as standard medical practices, and may be considered investigational or experimental. Medications prescribed may be approved by the FDA for a different condition than that for which it is prescribed for me. I understand my physician may request laboratory testing which may include venipuncture, analysis of stool, urine, saliva and breath.

NOTICE THAT SERVICES ARE NOT PRIMARY CARE*: I understand that no physician or any other practitioner I see at* **Rēbalance** *is acting as my primary care doctor unless otherwise agreed to by a physician in writing.* As such, emergency services are not offered. I understand that even though my physician(s) and The Center for the Healing Arts, PC practitioners may address issues affecting my general health, the practice is focused on a complementary, holistic approach to care and it is in my best interest to have a primary care physician to ensure that I am fully appraised of all available conventional means to address any medical conditions I may have. This is also important because these practices are exclusively office-based and are not affiliated with a hospital. If I become so ill that I require hospitalization, it is vital that I have a primary care physician with hospital admitting privileges familiar with my health problems and history. I understand that in addition to a primary care physician, it may be in my best interest to have appropriate specialists, such as a cardiologist if I have cardiac problems or a pediatrician if I am seeking treatment for my children. I also understand that it is my responsibility to inform **Rēbalance** who my primary care physician and specialists are, to let my physician know of any diagnoses I have received, and of any treatments I have had or am now undergoing for current conditions, and that I should keep my physicians and any practitioners I see informed on an ongoing basis. I also understand that it is very important to let my primary care physician know about any treatments performed **Rēbalance** in order to properly and safely coordinate my care.

My primary care physician is:

Name: _____ Address: _____

Phone: _____ City State Zip Code: _____

I am also being treated for _____ by:

Name: _____ Address: _____

Phone: _____ City State Zip Code: _____

FINANCIAL/INSURANCE RESPONSIBILITY FOR ALL Rēbalance SERVICES: I understand and agree to the following policies regarding financial and insurance responsibilities. Payment is required at each visit; **Rēbalance** does not accept assignment. I am responsible for charges incurred for all treatment rendered. This responsibility includes co-payments, deductible amounts, non-covered and excluded items not paid for by my insurance carrier or other party responsible for coverage of my medical expenses because differences between integrative and conventional medicine can lead to differences in views about medical necessity. I agree that I am responsible for any payments for services my insurance carrier determines, either now or at a later date, to be unreasonable or not medically necessary. I understand my responsibility to pay includes fees for laboratory and/or other clinical and diagnostic testing and/or services requested by my treatment practitioner(s). **Rēbalance** will not be obligated to take action on my behalf against an insurance carrier for collecting or negotiating my insurance claim. I also agree to be responsible for costs and expenses, including court costs, attorney fees and interest, should it be necessary for **Rēbalance** to take action to secure payment of an outstanding balance owed.

CANCELLATION AND/OR NO-SHOW POLICY: The clinic urges you to keep every appointment, as consistent treatment provides optimal benefit. In the event you need to cancel an appointment, we require at least

24hours notice (Mon - Fri). Patients who cancel without proper notice or fail to show for a scheduled appointment will be subject to a charge not less than fifty percent of the full visit fee for each occurrence.

NOTICE TO MEDICARE PATIENTS: The doctors at **Rēbalance** have opted entirely out of the Medicare program, which means that Medicare will not cover any services or procedures performed at **Rēbalance.** I understand that I will not be able to submit any claims to Medicare and that if I have a secondary insurance carrier that carrier may or may not choose to reimburse claims. I understand that I will need to sign a contract (Medicare Private Contract Agreement) agreeing not to submit to Medicare, that Medicare limiting fees do not apply, and that I will be financially responsible for any services received. I understand that Medicare will not be reviewing any claims, and that an opinion by Medicare that a service is not medically necessary in their view of care would not discharge my responsibility for payment of said services(s).

CLAIM MANAGEMENT & DOCUMENTATION REQUESTS: My treating practitioner(s) may respond to insurance and or documentation requests for information, but will not be obligated to take action on my behalf against an insurance carrier for collecting or negotiating my insurance claim. I understand I will be charged for responding to requests for information based on a rate of **$300.00 per hour**. Insurance claim forms and information will be provided to patients at the time of visit or sent to you upon the availability of the appropriate documentation. **Rēbalance**, and/or it's representatives do not make court appearances unless subpoenaed.

FURTHER NOTICES AS TO POLICIES REGARDING INSURANCE: **Rēbalance** will provide claim forms for submission to insurance; submission shall be the patient's responsibility. Claim submissions may or may not be for covered services and may or may not include procedural codes or other data sufficient to support my insurer's determination as to what services it will reimburse. **Rēbalance** may provide records requested by my insurance company. If possible, **Rēbalance** will advise whether my insurance will cover any particular expenses, but given the uncertainty that pervades insurance decisions,

NO GUARANTEES: I am aware that no practice of medicine is an exact science, and acknowledge that there are and can be no guarantees as to accuracy or outcomes of any diagnosis or treatments that I receive at **Rēbalance.**

REVOCATION OF AUTHORIZATIONS: These authorizations may be revoked by me in writing at any time. Such revocation will not affect my financial responsibility to pay for services rendered.

PATIENT ACKNOWLEDGMENT: I certify that the information I provide to my practitioners and my insurance company is correct. I certify that I am here to receive medical care and for no other purpose. I do not represent any third party.

By signing and dating this form, I acknowledge that I have received a copy of **Rēbalance**. Authorizations and Acknowledgements.

Patient's Signature:	Date:
Witness's Signature	Date: