AGREEMENT BY THE PATIENT / GARANTOR TO BE FINANCIALLY RESPONSIBLE FOR FEES

Our practitioner participate in many insurance plans, and as a courtesy to you we will submit claims to these companies on your behalf. Since we do not have knowledge of the details of every insurance plan available, and since every plan is different, please be sure to check your coverage if you have questions as to what your insurance will cover or pay for.

We will process your medical claims directly to your insurance carrier for you. While we make every effort to resolve insurance issues, please remember that you are ultimately responsible for your insurance benefits, as well as the cost of your health care. We are obligated by your insurance company to collect co-payments at each visit. Once your insurance company has determined the portion of our bill that you are required to pay, we will mail a statement of your account to you.

On occasion, insurance companies may send the payment for our services directly to you. In this event, it is important for you to contact our billing department to verify whether payment has been made to us for those billed services. If the clinic has not received payment for those services, you are required to reimburse the clinic for the charges, by either paying us directly or signing over the insurance company's reimbursement check.

I _____(patient or guarantor) understand that I am financially responsible for all charges whether or not paid by my insurance. I am aware that some and perhaps all of the services provided may be non-covered services under my insurance. I am also aware that verification of insurance benefits is not a guarantee of payment or coverage. I also understand that a monthly interest rate may be applied to any unpaid patient balance over 30 days past due.

Patient Signature:_____ Date_____

MEDICAL RELEASE TO INSURANCE COMPANY & NOTICE OF PRIVACY PRACTICES

I authorize the release of medical information to my insurance company / companies, including diagnosis and the record of treatment or examinations rendered to me during the period of such medical care, and also request my insurance company / companies to pay directly to Vibrant Health Acupuncture & Wellness Center, LLC for those medical services.

Patient Signature:_____ Date_____

AGREEMENT BY THE PATIENT REGARDING CANCELLED/MISSED APPOINTMENTS

Patient understands that a missed appointment (No Show) will result in full charges being issued for that appointment.

If a patient fails to give the clinic 24 hours notice of a change of appointment, the patient may be charged for that appointment.

Patient Signature:_____ Date_____

Clinic Verification of Signatures: _____ Date_____