Agreement of Financial Responsibility

Thank you for choosing us as your health care provider. We are committed to providing quality care and service to all of our patients. The following is a statement of our financial policy, which we require that you read and agree to prior to any treatment.

Patient Financial Responsibilities

- The patient (of patient's guardian, if a minor) is ultimately responsible for the payment for treatment and care.
- We will bill your insurance for you. However, the patient is required to provide the most correct and updated information regarding insurance.
- Patients are responsible for payment of co-pays, co-insurance, deductibles and all other procedures or treatments not covered by their insurance plan.
- If I am uninsured, I agree to pay for the medical services rendered to me at time of service.
- Co-pays are due at the time of service.
- Co-insurance, deductibles and non-covered items are due 30 days from receipt of billing. If you have a card on file, the card will be processed once the claim has processed through the insurance company.
- In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge of $125-$300 and agree to pay the costs of all services provided.
- If we are not contracted with your insurance company, you will be expected to pay for all services rendered at the end of your visit. We will provide you with a statement that you can submit to your insurance company for reimbursement.
- Patients may incur, and are responsible for payment of additional charges, if applicable. These charges may include.
    - Charge for returned checks
    - Charge of **$125** for missed appointments without **24 hours'** notice for Medication Management appointments and **72 hours**' notice for Therapy appointments.
    - Charge for extensive phone consultations and/or after-hours phone calls requiring diagnosis, treatment, or prescriptions.
    - Charge for the copying and distribution of patient medical records.
    - Charge for extensive forms completion.
    - Patient care will be suspended if an account exceeds $300.00.
    - Insurance rates are always subjected to change.
    - ESA Letters are $200 cash rate.
    - By my signature below, I hereby authorize assignment of financial benefits directly to Denver Wellness Associates for services rendered. I understand that I am financially responsible for charges not covered by this assignment.

I have read the financial policies contained above, and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

[ResponsiblePartyName]

[Signature]