Champlain Center For Natural Medicine

Patient Financial and Privacy Practices Agreement

Consent to Care

I understand that I have a right to be informed of all procedures and treatments recommended to me and I have the right to seek a second opinion from another health care professional. I understand that I may ask questions regarding my individual treatment and that I am free to withdraw my consent and to discontinue participation in or to refuse any specific procedure or treatment at any time. With this knowledge, I consent to the routine evaluation and treatment deemed necessary or advisable by the health care provider(s) responsible for my care, realizing that no guarantees have been given to me by Champlain Center for Natural Medicine.

Authorization to Release Medical Information

I agree to allow Champlain Center for Natural Medicine to release information regarding my medical treatment to any private or government insurance program that covers me, as necessary to verify benefits, authorize services, and process medical claims. In addition, release of medical records is authorized for any organization performing utilization review and any health care agency authorized by law.

Authorization to Assign Insurance Benefits

I request that payment of authorized benefits under any private or government insurance program that covers me, including Medicare and Medicaid, be made on my behalf directly to Champlain Center for Natural Medicine. I understand by signing this form I am authorizing Champlain Center for Natural Medicine to receive payments directly from any private or government insurance program that covers me for as long as I seek care at Champlain Center for Natural Medicine, or until I withdraw my consent in writing. I understand that I am liable to Champlain Center for Natural Medicine for all related charges, whether or not covered by insurance.

Statement of Financial Responsibility

I acknowledge that I am legally responsible for all charges for the services provided to me by Champlain Center for Natural Medicine to the extent those charges are not covered of paid by my insurance carrier/health plan or another payment source such as Medicare or Medicaid. I understand that my insurance carrier/health plan may not approve or pay for the medical services provided by Champlain Center for Natural Medicine. I understand that I am personally responsible for payment of all charges not paid in full, co-payments, policy deductibles, and co-insurance, except where my liability is limited by contract or State or Federal law. In the event of non-payment, I understand non-payment will be reported to credit reporting agencies and agree to pay all reasonable costs of collection including attorney's fees. Champlain Center for Natural Medicine is authorized to access credit bureau files and reports now and in the future for collection purposes.

I understand a $40.00 fee will be charged for a missed appointment; we require 24 hours cancellation notice. (Exceptions will be made for emergencies.)

Non-covered and/or Non-Medically Necessary Services

I acknowledge that I am legally responsible for all charges associated with the provision of non-covered and/or non-medically necessary services. I understand Champlain Center for Natural Medicine is not responsible for ensuring that I understand which services are not covered or are not considered medically necessary by my insurance carrier/health plan except where required by federal law. I understand it is my responsibility to review my insurance plan benefits and accept responsibility for payment should I choose to proceed with care.

_____ _____

Patient's Name (PRINT) **Patient's Guardian (Print)**

_____ _____

Signature of Patient **Signature of Guardian**

_____

Relationship to Patient

_____

Date

_____

Signature of Witness

For Official Use Only: Unable to Obtain Acknowledgement of Receipt

This section serves as a record of CCNM's good faith effort to obtain written acknowledgement from the patient of receipt of the Notice of Privacy Practices. Patient was given a copy of the notice on: _____

☐ Patient refused to sign acknowledgement

☐ Patient is physically unable to sign acknowledgement

☐ Other: _____

Procedure Informed Consent

I understand that I have a right to be informed of all procedures and treatments recommended to me and I have the right to seek a second opinion from another health care professional. I understand that I may ask questions regarding my individual treatment and that I am free to withdraw my consent and to discontinue participation in or to refuse any specific procedure or treatment at any time. The physicians at CCNM may recommend a procedure during an office visit to learn more regarding your unique situation. These procedures, along with the office visit, are billed to insurance and you are responsible for any costs your insurance does not pay. Some of these procedures are minimal in cost, others are more expensive. If you have do not have insurance that covers our services you will be charged for the visit or procedures when you check out at the front desk.

Procedures are done in office and are different from a test order. For example, CCNM will draw your blood and send it to a lab for processing. The drawing of the blood is a procedure we bill for, the lab processing the blood will bill you separately. An x-ray or ultrasound, for example are test orders done outside of the clinic.

Procedures we perform in office include but are not limited to:

Acupuncture

Blood Draw

Comprehensive Review of Data (This is a non-routine lab review such as 23&me that takes extra time and offers a different view of your health. We schedule extra time for this review and insurance will reimburse up to $200.00.) If you have a high deductible we encourage you to pay for this review in advance with a significant discount. If you have Vermont Medicaid, this review is not covered and you must agree to pay for this out of pocket before the visit is scheduled. We offer a discount of $100.00 to review this test. (Prices are subject to change without notice.)

Cranial Sacral Adjustments

Injections

ECG

Ear Wax removal

Oxygen

Urinalysis

Wart removal

Wound Care

I understand by consenting to any procedure that I may incur additional costs beyond the office visit that go to my deductible or are not covered by my insurance.

_____

Print Name

_____ _____

Signature Date