Advanced Integrative Healthcare
William Epperly, M.D.

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OFFICE POLICIES

- ☐ Scented products **may not be worn** in the office. This includes perfumed products, lotions, hair products, etc.
- ☐ Emails are for general office use. Health care issues **will not be addressed** through email.
- ☐ Cell phones should be silenced during office visits.

X____
Patient /Legal guardian

FINANCIAL POLICY

· As a recipient of medical care I, the undersigned, am responsible for all charges regardless of my circumstances for reimbursement.
· Advanced Integrative Healthcare (AIH) will bill only contracted insurances and will comply with the terms of those contracts. Coverage is dependent on individual policies and it is my responsibility to know what the terms of my insurance are.
· **AIH will not bill secondary insurances or third parties** (accident, work comp, etc.)
· I will provide AIH with complete and accurate insurance information including a current insurance card.
· In the case of divorce, **the parent who is financially responsible must sign this consent**. Parents are expected to work out payment arrangements with each other and not involve AIH in any disputes.
· Patient **copays** and **balances are due immediately** and are not contingent on receiving a bill or statement from AIH.
· A **$5.00 late fee will be applied monthly to any patient balance that is over 30 days**. If I default on my account and the balance is referred to a collection agency or attorney, I will be responsible for all costs of collecting monies owed, including interest, court costs, collections agency and attorney fees. There will be a $35.00 service charge for any returned check.

UNIVERSAL CONSENT

· I understand that by presenting myself for health care services, I authorize and consent to basic medical care provided by AIH.
· I understand that the practice of medicine is not an exact science and there are no guarantees as to the diagnosis or result of examination or treatment in this office.
· I have read and agree with the financial agreement and office policies as outlined above.
· I authorize the release of medical and financial information that may be requested by my insurance company.
· I understand that a copy of “Patient’s Bill of Rights” and the Health Privacy Notice is available on the AIH website or may be obtained upon request.

I give permission for my (or my dependent’s) medical information to be communicated with myself and the following people:

1.____ ☐ answering machine ☐ appt. reminder call on machine
2. ____ ☐ telephone
3. ____ ☐ e-mail ________________________________

X____ ________________________
Patient / Legal guardian Date