WARNER WELLNESS INSTITUTE

Statement of Patient Financial Responsibility

Patient Name: _____ DOB: _____

WARNER WELLNESS INSTITUTE appreciates the confidence you have shown in choosing us to provide for your health care needs. The service you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full for our fees. As a courtesy, we will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. We expect these payments at time of service. Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved period, you will be responsible for your balance in full.

I have read the above policy regarding my financial responsibility to WARNER WELLNESS INSTITUTE, for providing medical services to me or the above named patient. I certify that the information is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Green Pregnancy and Center for Women's Health, the full entire amount of bill incurred by me or the above named patient; or, if applicable any amount due after payment has been made by my insurance carrier.

Patient Signature_____ Date_____

Guarantor Signature_____ Date_____

(If guarantor is not the patient)

Co-Pay Policy

Some health insurance carriers require the patient to pay a co-pay for services rendered. It is expected and appreciated at the time service is rendered for the patients to pay at EACH VISIT. Thank you for your cooperation in this matter.

Patient/Guarantor Signature_____Date_____

Consent for Treatment and Authorization to Release Information

I hereby authorize WARNER WELLNESS INSTITUTE, through its appropriate personnel, to perform or have performed upon me, or the above named patient, appropriate assessment and treatment.

I further authorize WARNER WELLNESS INSTITUTE, to release to appropriate agencies, any information acquired in the course of my or the above named patient's examination and treatment.

Patient/Guarantor Signature_____Date_____

Cancellation/No Show Policy

We understand there may be times when you miss an appointment due to emergencies or obligations to work or family. However, we urge you to call 24-hours (one business day) prior to cancelling your appointment or rescheduling your appointment or you will be charged a $50.00 fee.

I have read and understand the above information, and I agree to the terms described.

Patient/Guarantor Signature_____Date_____

Form Completion and Replacement for Lost Items

Should you require forms for employment, school, disability, or any other purpose; you must assume the cost of preparing these forms. There must be a signed authorization form from the patient accompanying these forms. Forms request must be provided at least one week before the due date. The charge for form completion is $25.00 per form.

The practice provides prescriptions that are medically necessary and appropriate in your treatment, referrals for radiology, and requisitions for laboratory testing. If any of these items are lost and a replacement is necessary; there is a $25.00 fee that must be paid before the replacement is provided.

Patient/Guarantor Signature_____Date_____

.Self-Pay

I do not have health insurance and will be responsible for services rendered here at WARNER WELLNESS INSTITUTE. I agree to pay WARNER WELLNESS INSTITUTE, the full and entire amount of treatment given to me or to the above named patient at each visit.

Patient/Guarantor Signature_____Date_____