Champlain Center for Natural Medicine

Patient Financial and Privacy Practices Agreements

*Please read and initial each section and sign where asked

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 (CCNM).

_____ (initial)

Authorization to Release Medical Information

I agree to allow CCNM 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.

_____ (initial)

Authorization to Assign Insurance Benefits

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

_____ (initial)

Statement of Financial Responsibility

I acknowledge that I am legally responsible for all charges for the services provided to me by CCNM to the extent those charges are not covered or paid by my insurance carrier/health plan or another payment source. I understand that I am personally responsible for payment of all charges not paid in full, co-payments, policy deductibles, and co-insurance.

_____ (initial)

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 CCNM 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.

_____ (initial)

Financial Policy

CCNM is willing to work with patients and can offer payment plans with billing approval. CCNM will bill twice over two months before adding late fees. After the third billing cycle, if a payment plan has not been established or the bill has not been paid in full, I understand my balance will be considered delinquent for non-payment.

In the event of non-payment, I understand my bill in its entirety will be reported to a credit reporting agency and I agree to pay all reasonable costs of collection including attorney's fees. CCNM is authorized to access credit bureau files and reports now and in the future for collection purposes. By signing this form, I acknowledge that I understand and agree to the policies stated above.

_____ (initial)

Cancellation/No-show Policy

I acknowledge that I must give at least **24 business hours' notice** (Mon-Fri) for cancellations or rescheduling of appointments. If an appointment is not cancelled within 24 hours CCNM policy is:

1st time: I will be charged a $40 fee

2nd time: I will be charged the fee of the entire visit.

3rd time: I will only be offered to schedule same-day appointments.

When a patient does not call to cancel an appointment, they are preventing another patient from getting much-needed treatment. We at Champlain Center for Natural Medicine understand that emergencies happen and exceptions will be made in those cases.

By signing below, I acknowledge that I understand and agree to the policies of CCNM stated on this form.

_____ _____

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

_____ _____

Signature of Patient Signature of Guardian

_____ _____

Date Relationship to Patient

_____

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: _____

Champlain Center for Natural Medicine
Procedure Informed Consent

By signing this form, I acknowledge that 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 do not have insurance that covers our services you will be charged for the visit and 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

EKG

Ear Wax removal

Injections

IV Therapy

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.

_____ _____
Patient Name Guardian name if patient under 18

_____ _____
Signature Date