

Financial Agreement



Cash-Based Medical Services Financial Agreement

This financial agreement is entered into on this day, by and between the patient and the medical practice, Salud Natural Wellness/ Gemma Coronel, ND.

1. Service and payment terms

- **Cash-based services:** The Provider operates on a cash-based or "direct pay" model. This means that the Provider does not have contracts with any private health insurance companies, Medicare, or other government payers. The Provider is considered an out-of-network provider for all insurance plans.
- **Payment at time of service:** The Patient agrees to pay for all services in full at the time of the appointment. Payment is a necessary part of the treatment and a condition for receiving services.
- **Accepted payment methods:** The Provider accepts the following forms of payment: cash, check, credit card, debit card, HSA/FSA card.
- **Fee schedule:** The Patient acknowledges receipt of the Provider's current fee schedule, which lists the costs for common services. The Provider reserves the right to update its fee schedule and will provide notification of any changes.

2. Insurance coverage and billing

- **No insurance billing:** The Provider will not bill the Patient's insurance company for services rendered. This eliminates the administrative burden and billing issues associated with third-party payers.
- **Patient responsibility for reimbursement:** If the Patient chooses to seek reimbursement from their insurance company, it is the Patient's sole responsibility to submit claims.
- **Documentation for patient claims:** The Provider will furnish the Patient with a detailed invoice or a "superbill" containing the necessary information (e.g., CPT codes, diagnosis codes) that the Patient can submit to their insurance company. The Patient acknowledges that receiving this document does not guarantee insurance reimbursement.
- **No guarantee of coverage:** The Patient understands that the Provider makes no promise or guarantee of payment or coverage from any insurance carrier. Insurance benefits vary, and the

Patient is responsible for knowing their own policy's coverage details and requirements.

3. Financial responsibility

- **Full financial responsibility:** The Patient, or the Patient's authorized representative, agrees to be fully responsible for all fees and charges associated with the medical services provided.
- **Failure to pay:** In the event that payment is not received at the time of service, the Provider reserves the right to charge an administrative fee of \$25 for late payments. The Provider may also suspend further treatment until the outstanding balance is settled.
- **Collections:** If the account remains unpaid after 30 days, the Provider may pursue collections efforts, and the Patient will be responsible for all costs of collection, including attorney fees.

4. Additional policies

- **Cancellation/No-show policy:** A fee of \$50 will be charged for any missed appointment or for a cancellation with less than 24 hours' notice.
- **Returned checks:** A fee of \$25 will be charged for any returned check. After a returned check, the Patient may be required to pay for future services in cash/debit only.
- **Records disclosure:** The Patient has the right to request that any medical records from this visit not be disclosed to their insurance plan.

5. Consent and signature

By signing below, the Patient acknowledges that they have read, understood, and agree to the terms of this financial agreement. The Patient voluntarily accepts full financial responsibility for all services provided by the Provider.

Printed name of Patient

Legal first name

Last name

Date:

Patient/Guarantor Signature:	
<div>X</div>	
Print name:	Date: