FINANCIAL POLICY

All charges may not be determined at point of service. If additional charges are identified, we will bill the patient's insurance or the patient if paying privately.

Thank you for choosing us as your healthcare provider. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of our Financial Policy which we will require you to read, initial and sign prior to any treatment. All patients must complete our information and insurance form before seeing the Provider.

* Picture ID is required on all adult patients.
* A $25.00 fee will be added to all returned checks.
* A $10.00 rebilling fee will be added each month to all statements sent out.
* A $100.00 administration fee will be added to any account turned to an outside collection agency for non-payment.

Non-Contracted Insurance Companies Or Provider: You must have a valid ID card for your insurance company complete with the billing address. We will be happy to bill your insurance company; however if no payment is received, the balance is your responsibility. Your insurance policy is a contract between you and your insurance company. We are not part of that contract. Please contact your insurance company to see if Portland Wellness Care is a contracted provider. Please be advised Portland Wellness Care may be listed as a contracted clinic with your insurance company but that does not guarantee the Medical Provider that is on duty today is contracted with your insurance company. Our policy is to credential each and every Provider with our contracted insurance companies but because the insurance company has up to 90 days to respond and for other various reasons out of our control, it is not always possible to ensure all of our Providers will be in-network with your insurance company at the time of your visit. We are happy to see you for your medical needs and we will bill your insurance but please be aware that if the Provider is out-of-network, the patient or the patient's guarantor will be held responsible for the non-covered balance. We apologize for any inconvenience this may cause.

Contracted Insurance Companies: As a courtesy we will gladly bill your insurance company for you. All co-payments are due at the time of service. You must have a valid ID card for your insurance company complete with the billing address. In the event your insurance denies service, Portland Wellness Care retains the right to bill you as the responsible party for reimbursement.

Usual And Customary Rates: Portland Wellness Care is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payments of your insurance company's arbitrary determination of usual and customary rates.

Minor Patients: Adults, Parents or Guardians accompanying a minor are responsible for the patient fees incurred at the office visit. For unaccompanied minors under the age of 15, non-emergency treatment will be denied. Unaccompanied minors over 15 years of age will be denied treatment, if prior arrangements have not been made.

Cancellation Policy: We require that you give 24 hours' notice in the event that you cannot make it to your scheduled appointment. This will enable us to offer your canceled time to other patients that desire to get their treatment completed. If a patient misses an appointment without contacting our office, it is considered a "missed" or "no show" appointment. You will be charged a $50.00 fee. Additionally, if you miss more than three appointments, we reserve the right to discharge you from the practice for failing to follow treatment recommendations. If you have any questions regarding this policy, please let my staff know, and we will be happy to clarify the policy for you. We look forward to being a continued part of your wellness.

We accept cash, check or credit cards.

The signing of this document indicates I, _____, have read and understand the above
(Please print first and last name)
Financial and Cancellation Policy and agree, I will be responsible for any balance owing on my visit today.

Sign: _____ Date: _____

ACKNOWLEDGEMENT AND CONSENT

I understand that Portland Wellness Care will use and disclose health information about me. I understand that my health information may include information both created and received by Portland Wellness Care may be in the form of electronic

or written records or spoken words, and may include information about my health history, health status, symptoms, examinations, test results, diagnoses, treatments, procedures, prescriptions, and similar types of health related information.

I understand and agree that Portland Wellness Care may use and disclose my health information in order to:

- make decisions regarding my care and treatment;
- refer to, consult with, coordinate among, and manage along with other health care providers for my care and treatment;
- determine my eligibility for health plan or insurance coverage, submit bills, claims and other related information to insurance companies or others who may be responsible to pay for some or all of my health care; and
- perform various office, administrative and business functions that support my physician's efforts to provide me with, arrange and be reimbursed for quality, cost effective health care.
- send and receive prescription information electronically and verbally from pharmacies

I also understand that I have the right to receive and review a written description of how Portland Wellness Care will handle health information about me. This written description is known as a Notice of Privacy Practices and describes the uses and disclosures of health information, the information practices followed by the employees, staff and other office personnel of Portland Wellness Care and my rights regarding my health information.

I understand that the Notice of Privacy Practices may be revised from time to time, and that I am entitled to receive a copy of any revised Notice of Privacy Practices. I also understand that a copy or a summary of the most current version of Portland Wellness Care's Notice of Privacy Practices is posted in the waiting room/reception area.

I understand that I have the right to ask that some or all of my health information not be used or disclosed in the manner described in the Notice of Privacy Practices, and I understand that Portland Wellness Care is not required by law to agree to such requests.

By signing below, I agree that I have reviewed and understood the information above and that I have received a copy of the Notice of Privacy Practices.

Sign: _____ Date: _____
(Patient)

Sign: _____ Date: _____
(Patient Representative)

Description of Representative's Authority: _____

Informed Consent to Treatment

To the patient or their parent, legal guardian: Please read this entire form prior to signing it. It is important that you understand the information contained in this form. Please ask any questions prior to signing this form if you are unclear about anything in this form.

A physical examination will be performed to obtain a baseline level of functioning as well to partially determine an appropriate course of treatment and associated recommendations. The physical examination may include posture checks, X-rays, diagnostic ultrasound, range of motion testing, muscle strength testing, various neurological and orthopedic testing, and other testing. Radiology is the use of x-rays on the human body and is used to gain an inside perspective of the human body that cannot be obtained from a physical examination. Additionally, there may be referrals to other doctors as necessary.

The vast majority of our patients tend to achieve good to excellent improvement in their physical conditions with the use of physical medicine and in conjunction with other modalities. Improvement can be measured in many different ways, including reduction in pain, increased range of motion, less stiffness, increased athletic performance, and other ways. It must be remembered that different people get different results; different people have pre-existing conditions, and are of different ages and occupations (with different types of physical stress). Your situation is unique, and no guarantees are given.

I understand and am informed that, as in the practice of medicine and all healthcare, the practice of physical medicine, massage therapy, acupuncture carries some risk to treatment: some including, but limited to: fracture, disc

injuries, strokes and sprains. I understand acupuncture is a safe therapy, but there are some possible side effects. I may experience bruising, tingling, discomfort and pain close to the sites of needling or cupping that may last for several days. Nausea, lightheadedness or dizziness occasionally occur following treatment. I understand it is best to eat a snack or light meal 1-2 hours prior to treatment, to avoid these symptoms.

I understand if I am receiving massage therapy, physical medicine, or acupuncture, I do not expect the physicians at Portland Wellness Care to be able to anticipate and explain all risks and complications. Further, I wish to rely on the physician(s) to exercise judgement during the course of the procedure with what the physician feels are in my best interests at the time, based upon the facts then known.

By: Date:

Patient/Responsible Party Signature