

# Northwest Health & Healing Center

## BILLING CONSENT

**This office will contact your insurance company to try to determine your benefits. We strongly suggest that you also contact the insurance company to confirm your benefits. We will communicate to you what benefits we were quoted. There is absolutely no guarantee that what the insurance pays will match the quoted benefit. You should anticipate that there will be some balance still owed even after you have paid your co-payment or co-insurance.**

**This office will bill my insurance company as a courtesy. There is no assurance that my insurance company will pay all or some of my charges. I understand that I am ultimately responsible for charges associated with my account. I also understand that if I do not take care of my balance within a reasonable amount of time, Dr. House or Dr. Sorah may exercise the option of sending my account records to a collection agency.**

**Please note:** We have a new cancellation fee in our office. If you give 24 hours notice, there is no charge to change/cancel your appointment. If you cancel after this time, it will result in a \$45 fee. **Please note this change!** The advance notice of your appointment change allows other patients to be scheduled in your cancelled time slot. Thank you!

Patient/Guardian Signature \_\_\_\_\_ Date \_\_\_\_\_

### Insurance Information (if applicable)

#### Subscriber Information

Name

Date of Birth

Employer

Insurance Name: \_\_\_\_\_

Insurance Address: \_\_\_\_\_

Insurance Phone #: \_\_\_\_\_

Subscriber ID #: \_\_\_\_\_ Group #: \_\_\_\_\_

Is this related to an auto accident or a work injury?    Yes    No.

If yes please complete the following.

Claim #

Adjuster Name

Date of Injury

\_\_\_\_\_