Please initial the end of each paragraph after you have read and understood each statement.

Informed Consent: I have read the description of the risks and benefits of services and therapies provided by Elixia Wellness Group. I agree to these services, except those circled as declined below. I have been offered a copy of these descriptions, and if accepted, received a copy.

Initial _______

At this time, I **decline** receipt/use of the following services or treatments (circle all that apply):

Acupuncture Manipulation Naturopathic Medicine Bodywork/Massage

Supplements Microcurrent Imaging & Referrals

Initial _______

Notice of Privacy Practices: I have read and agreed to the Elixia Wellness Group Privacy Practices revision #2003. I have been offered a copy of these policies, and if accepted, received a copy.

Initial _______

Patient and Payment Policies:

Insurance. Many of our practitioners are contracted with a number of insurance plans. If your visit will not be covered by an insurance plan, or if you fail to provide proof of insurance, payment in full is expected at each visit. We will verify your insurance coverage as a courtesy, but knowing your insurance benefits is your responsibility, so please contact your insurance company with any questions you may have regarding your coverage. We will apply a 20% discount to services paid in full at time of service if you elect to bill your own insurance carrier for reimbursement.

Initial ______

Co-Payments and Deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company. In the event we bill your insurance carrier and the claim is returned to us because the deductible has not been satisfied, we will bill you for those services. Please understand that it could take several months between the time of service and the issuing of our billing statement once we receive notification from your insurance carrier regarding your deductible balance.

Initial______

Non-Covered Services. Please be aware that some, and perhaps all, of the services you receive may not be covered or considered reasonable or customary by Medicare and other insurance carriers. These services must be paid for at the time of your visit. In the event we bill your insurance carrier and the claim is returned to us because the services are not covered, we will bill you for the non-covered services. In addition, supplements, or any other prescribed

apparatus may not be covered by your insurance plan, or may require prior authorization. If authorization is needed, we will assist you in any reasonable manner to obtain coverage, however, insurance coverage for your prescriptions is ultimately beyond our control.

Initial ______

Insurance Claim Submission. We will be happy to submit both your primary and secondary insurance claims on your behalf, provided that you have supplied us with the needed billing information. We will assist you in any way we reasonably can to help you get your claims paid. Your insurance company may on occasion ask you to provide them with additional information. It is your responsibility to comply with their request. Please be aware that the balance of your claim is your responsibility whether or not your insurance pays your claim. Your insurance benefit is a contract between you and your insurance company; we are not party to that contract. Please be aware that Oregon Law requires insurance claims to be paid within 30 days of submission. If they do not comply after 90 days, this balance will be billed to you.

Initial ______

Insurance Coverage Changes. If you have an insurance change, please let us know before your next visit, so that we can make the appropriate changes to help you maximize your insurance benefits.

Initial_______

Cash Patients. Cash patients will receive a 20% discount if paid in full at time of service. The acceptable forms of payment are cash, personal check, or credit card. This discount does not apply to supplements, diagnostics, and most IV or injection therapies, or if there is another discount being honored at time of service.

Initial _______

Returned Checks. If your check is returned for insufficient funds, there will be a $25.00 Returned Check fee added to your account, in addition to the amount the check was for. Recovery of funds is automated through our bank's FARS /ECR service, which collects promised monies on our behalf.

Initial ______

Nonpayment. If your account is over 90 days past due from our first billing sent to you, it will be referred to a collection agency for payment. By signing this agreement you will also authorize the office to release information needed to secure payment.

Initial ______

Missed Appointments. If you miss your appointment or cancel with less than 24 hours notice, you will be charged a $35 missed appointment fee after the second occurrence.

Initial _______

I have read and understand the policies and agree to abide by the guidelines.

___________________________________ ___________

Signature of patient or responsible party **Date**

Thank you for understanding our policies. Please let us know if you have any questions.

Elixia Wellness Group, LLC
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Fax (503) 234-6094