



WELCOME TO OUR OFFICE

We are committed to providing you the best care and are pleased to discuss our professional fees with you at anytime. Your clear understanding of our financial policy is important to our professional relationship. Please ask any questions you may have regarding our fees or your responsibility in complying with our financial policy and/or procedures.

- Cash Patients:** Payment is due when services are rendered. We gladly accept MC, Visa, check /cash.
- Massage:** Please be aware, anyone failing to give 24 hour notice to cancel a massage appointment or failure to show for a massage appointment will be charged a \$25 fee for an hour massage/\$15 for a half hour massage. (This applies to both Insurance and Time of Service Patients.)
- Insurance Patients:** Please pay 20%, or your co-insurance %, for your first visit charges. Professional services are rendered and charged to your insurance on your behalf. Any services not covered by your insurance are ultimately your responsibility and may have to be paid by you at the time of service. If you fail to keep your scheduled appointments or if you discontinue care for any reason other than discharge by the doctor, the bill is due and payable by you in full, immediately, regardless of any insurance claims submitted. Our office accepts billing for Individual or Group Insurance policies, Personal Injury claims, authorized Worker's Compensation and Medicare.
- Collection/Attorney Fees:** I agree to pay all costs of a collection agency if necessary to obtain payment in the event legal action should become necessary to collect an unpaid balance due for medical services. I agree to pay reasonable attorney's fees or other such costs as the court determines proper. **NOTICE:** In the event that payment is not made on this account and it is placed with a Licensed Collection Agency, I/We agree to pay the fees of the Collection Agency equal to a maximum fee of 50% of our outstanding balance at the time the account is placed with the Collection Agency. Interest of 10% per year will be accrued on the Principal Balance. Should legal action also be necessary to collect on the account, I/WE will be responsible for any attorney's fees and court cost incurred for collection.
- Authorization to Process Drafts:** I agree that Health Solutions Wellness Center shall be appointed as my agent to endorse drafts on any checks for payment of my bill for medical services rendered.
- Limited Release of Medical Information:** I authorize Health Solutions Wellness Center to make inquiries and to release any pertinent information to any insurance company, adjuster or attorney to facilitate collection under these assignments.
- Assignment of Cause of Action:** In the event that any insurance company or other third party obligated to make payment to me or to Health Solutions Wellness Center for the charges made for the services, refuses to make such payment upon demand, I hereby direct any and all insurance carriers, attorneys, agencies, governmental departments, companies, individuals, and/or other legal entities ("payers") which may elect or be obligated to pay benefits to me for any medical conditions, accidents, injuries, or illnesses, past or future ("condition"), to pay directly to, and exclusively in the name of, **Health Solutions Wellness Center ("HSWC")** such sums as may be owing to **HSWC** for charges incurred by me, including but not limited to, charges for treatment, narrative reports, depositions, testimony, and any other charges incurred by me at the Office ("charges"). I further grant a contractual lien to **HSWC** with respect to my charges, applicable to all payers, however, I understand that nothing in this agreement shall be construed as an election by **HSWC** to claim protection under any statutory lien law. For the purposes of this Agreement, "benefits" shall include, but shall not be limited to, proceeds from any settlement, judgment, or verdict, as well as any proceeds relating to commercial health or group insurance, disability benefits, worker's compensation benefits, medical payments benefits, personal injury protection, lost wages benefits, lost services benefits, no-fault coverage, uninsured and underinsured motorist coverage, third-party liability distributions, malpractice proceeds, attorney retainer agreements, and any other benefits or proceeds payable to me for the purposes stated herein, regardless of whether such proceeds are related to my charges or not. I hereby assign, transfer and convey to Health Solutions Wellness Center any and all cause of action that might exist in my favor against any such company or person. I authorize Health Solutions Wellness Center to prosecute said action in my name or their name to collect fees due for care rendered and legal expenses, and to resolve said claims as they see fit.

Responsible Party Signature _____

Date: _____

Print Name _____

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