

**Bio Energy Medical Center**  
**Statement of Patient Financial Responsibility**

**Patient Name:** \_\_\_\_\_ **Date** \_\_\_\_\_

Thank you for choosing Bio Energy Medical Center for your healthcare needs. The service/services you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of our fees. For patients who have insurance, we gladly accept most insurance; but we **DO NOT** participate with any managed care programs such as PPO's or HMO plans. Many of these insurances do provide out-of-network benefits. If your plan provides out-of-network benefits, as a courtesy, we will bill your insurance carrier on your behalf. However, *you are ultimately responsible for payment of your bill. Please take time to become familiar with your benefits, particularly your deductible and co-pay responsibilities.* It is the responsibility of the patient to ensure that the insurance information on file is current. Any changes must be brought to the attention of the clinic as soon as possible to ensure accurate billing.

**You are responsible for payment of any deductible and co-payment/co-insurance** as determined by your contract with your insurance carrier. Most insurance companies *require* you pay the co-pays and/or deductibles at the time of service and may have additional stipulations that may affect your coverage. You are responsible for any amounts not covered by your insurer. If your insurance carrier denies any part of your claim, or if an insurance carrier has not paid within 90 days of billing, professional fees are due and payable in full from you. Non-covered services and patients without insurance coverage will require payment in full at the time services are provided.

I have read and understand the above Policy, and I agree to the terms describe: **Initials** \_\_\_\_\_

**Package Purchase Policy**

Many of our non-billable services are needed on a regular or frequent basis. In an effort to help decrease costs, we offer packages at a discount rate. These packages are **non-refundable** should I choose to purchase one.

I have read and understand the above Package purchase Policy, and I agree to the terms describe: **Initials** \_\_\_\_\_

**Cancellation / No Show / Late Arrival Policy**

We kindly ask that you let us know **24 hours** in advance if you are unable to keep your appointment. No-shows and same day cancellations will be **charged 50%** of the service/office fee. We respect your time and operate our business in a timely manner. We do not double book patients; and in consideration of other patients, we regret that late arrivals will not receive an extension of scheduled service time and will be responsible for full service/office fees. Some appointments may need to be cancelled due to late arrival.

I have read and understand the above Cancellation / No Show /Late Arrival Policy, and I agree to the terms described: **Initials** \_\_\_\_\_

**IV Policy**

Some patients require intravenous therapy as part of their treatment. Should you schedule an appointment for IV therapy, we require 24 hours notice to cancel. Same day cancellations and no-show appointments will be charged 100% of the fee if the IV has been prepared for their appointment.

I have read and understand the above IV Policy, and I agree to the terms described: **Initials** \_\_\_\_\_

I have read the above policies regarding my financial responsibility to Bio Energy Medical Center for the above named patient. I authorize my insurer to pay the full amount (less deductible and co-payment/co-insurance) of charges incurred by the above named patient directly to Bio Energy Medical Center.

Patient/Guarantor Signature \_\_\_\_\_ Date \_\_\_\_\_