1330 Cesar E. Chavez Blvd, Portland, OR 97214
Phone: 503-232-1100 Fax: 503-232-7751 Web: www.cnmwellness.com

PATIENT ELIGIBILITY WAIVER & FINANCIAL RESPONSIBILITY FORM

The purpose of this form is to help our patients understand their medical insurance, eligibility, coverage/benefits, and our office policy and medical services.

It must be understood that:

- We render our service on the basis that insurance companies may or may not pay all, or a portion of our charges for your visit(s).
- Authorizations for medical treatment from your insurance company do not guarantee full payment for authorized services.
- The patient/guardian is responsible for obtaining prior authorization (when applicable) prior to their visit.
- Not all insurance companies/third party payors pay for all services. Each policy has its own particular stipulations regarding covered services or amount of coverage. We will make every effort to obtain benefits on your behalf, but it is also your responsibility to know and understand your benefit plan with your insurance company.
- All insurance companies state that verification of coverage is not a guarantee of coverage and/or payment. Actual benefits are determined by your insurance company after a claim is received.
- Patients are personally responsible for knowing and understanding their own Insurance policy/plan benefits and eligibility with said insurance company.
- Patients are responsible for payment of outstanding deductibles and co-insurance.
- Co-payments will be collected at the time of service.
- Patients/guardians are responsible for payment for all non-covered services/procedures with their health plan.
- Any appointment that has been missed / not cancelled within 24 hours of their scheduled appointment will incur a $50.00 charge.
- Returned checks will incur a $35.00 service fee.
- Changes in a patient/guardian's insurance must be reported to our front desk staff promptly to avoid financial responsibility.

Center for NATURAL MEDICINE INC

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The patient or Patient's Legal Representative (Guardian) hereby acknowledges that he/she is Eligible for Health Insurance Benefits and coverage. That in the event that the patient is not eligible for insurance and coverage with said insurance policy, he/she understands and agrees to be fully financially responsible for payment of all costs incurred during the delivery of health services delivered by a Center for Natural Medicine Provider.

Patient Name_____ Date_____

Signature of patient / Guardian_____ Date_____

CNM Staff_____ Date_____