Natural Choices Health Clinic

Your natural choice for health care

3007 SE Belmont Street, Portland, OR 97214 ph: (503) 445.7115 fax: (503) 445.7116
www.NaturalChoicesClinic.com info@NaturalChoicesClinic.com

Dear New Patient,

Welcome to our clinic. We, the healthcare providers at the Natural Choices Health Clinic, look forward to providing for your health needs. We encourage your questions and participation in all aspects of your health care. **Please read and initial the following**:

_____ **I understand that full payment for all services and products I receive from Natural Choices Health Clinic and its practitioners is required at the time of service, except that portion billed to my insurance company.**

_____ **Further, I understand that Natural Choices Health Clinic may submit my bill to insurance carrier, if I so request, and that I am responsible for any services not covered by my insurance company, as well as, any co-pay, coinsurance or deductible required by my insurance.**

_____ **You will be charged a Missed Appointment fee of $75.00 for any missed appointments. This includes late cancellations with less than 24 hours notice or arriving more than 15 minutes late to your scheduled appointment.**

_____ **I give permission for the staff at NCHC to contact me via telephone or email and leave a message that may contain appointment or medical information if I am not available.**

_____ **I hereby give my consent for Natural Choices Health Clinic to use and disclose protected health information about me to carry out treatment, payment and health care operations. The Notice of Privacy Practices provided upon request describes such uses and disclosures more completely.**

We accept MasterCard, VISA, Debit cards, checks, and cash. There will be a charge of $25.00 for returned checks due to insufficient funds. We can arrange payment plans.

You recognize, understand and agree that your health care provider is a sole practitioner and is not a partner or otherwise affiliated with any other health care provider who may be providing similar services at the Natural Choices Health Clinic. You further recognize, understand and agree that your health care provider is solely responsible for and shall provide all professional services to you, and you are relying solely on your practitioner's skill for the professional services rendered at the Natural Choices Health Clinic.

Your health care provider may prescribe medication, which may be purchased either at the Natural Choices Health Clinic or elsewhere. Most insurance companies do not cover the pharmacy items that we prescribe and dispense.

I have read and understand the above-stated policies of the Natural Choices Health Clinic and will comply with them in all respects. If my insurance company requires release of my medical records, I hereby give my permission by signing this form.

_____
Your Signature (parent or guardian if minor)

_____ _____
Print your name (parent or guardian if minor & patient name) Date