Your Natural Dr LLC
SPARK HARMONY IN YOUR HEALTH!

AUTHORIZATION FOR TREATMENT, HIPAA PRIVACY POLICY, ASSIGNMENT OF BENEFITS, FINANCIAL POLICY, RELEASE OF INFORMATION, ELECTRONIC COMMUNICATION

CONSENT FOR TREATMENT: By this document, I do hereby request and authorize Your Natural Dr LLC, its medical practices & providers including Dr. Michelle Hessberger, technicians, nurses, and other qualified personnel to perform evaluation & treatment services and procedures as may be necessary in accordance with the judgment of the attending medical practitioner(s). I acknowledge that no guarantee can be made by anyone concerning the results of treatments, examinations or procedures. I understand that Dr. Michelle Hessberger is available to explain all treatments and I have the right to refuse treatment.

PRIVACY NOTICE: We are required by law to maintain the privacy of and provide individuals with, this notice of our legal duties and privacy practices with respect to health information. In compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) we have our HIPAA Notice of Privacy Practices on display in the reception area and a printed copy of the HIPAA notice will be provided upon request. If you have any objections to this form, please ask to speak with us in person or at our main phone number as listed on this form. By signing this form, I acknowledge that I have received and understand the Health Information Privacy Notice for Your Natural Dr LLC and Dr Michelle Hessberger, which is also available online at www.yournaturaldr.com. I understand as part of my health care, this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for further case or treatment.

INSURANCE AUTHORIZATION AND ASSIGNMENT OF MEDICAL BENEFITS: I request that payment of authorized medical benefits be made on my behalf directly to Michelle Hessberger ND, LAc and Your Natural Dr LLC. I authorize Your Natural Dr LLC to release any medical information to my health insurance carrier and/or its legitimate agents that is necessary to process related health insurance claims and/or to verify plan benefits in accordance with HIPAA health information standards. I authorize payment of service(s), otherwise payable to me under the terms of my private, group employer's or group health insurance plan, directly to Your Natural Dr LLC and Dr. Michelle Hessberger. I understand that this authorization may not result in full payment by my insurance carrier for the charges incurred and I agree that I am financially responsible to make payment in full on remaining patient balances should my insurance carrier determine the services I received are not covered. I further understand and agree to pay for the services or amounts due when appropriate. These charges could include amounts applied to my annual deductible, copayment amounts, and charges denied as not covered by my insurance program or deemed medically necessary. I acknowledge that a copy of this authorization shall be considered valid.

REFERRAL: I understand that if my insurance requires a referral from my primary care provider for specialist services and if I do not have the referral at the time of the appointment, and I still choose to receive the services without the required referral, then it will be my responsibility to contact my primary care provider's office the same day and obtain the necessary referral, dated for the date of the service. I also accept full financial responsibility for all charges incurred for services received on the day of service if my insurance carrier denies the claim(s) for lack of and/or invalid referral.

PAYMENT: I do hereby guarantee payment of all fees and charges related to all services and durable goods provided to me through Your Natural Dr LLC and Dr. Michelle Hessberger from my first date of examination or treatment. I agree to make full payment immediately upon receipt of a Your Natural Dr LLC billing statement whether it is an interim or final bill. Payments for all services will be due at the time services are rendered. In order to serve you better, we accept cash, check, Visa, MasterCard, PayPal and American Express. As a courtesy to you, it is the policy of Your Natural DR LLC to bill your insurance carrier, although you are ultimately responsible for the entire bill.

As the responsible party, please understand:

1. Your insurance policy is a contract between you, your employer, and the insurance company. We are not a party to that contract. Our relationship is with you, not your insurance company. We will not become involved in disputes between you and your insurer regarding deductibles, co-payments, covered charges, secondary insurance and "usual and customary" charge. As your medical provider, we will only supply factual information to facilitate claim processing.

2. It is your responsibility to know and understand your own insurance program. It is your responsibility to know the amount of your insurance deductible. It is your responsibility to know whether this office is participating with your particular insurance plan and program. It is your responsibility to know if you need a referral or preauthorization for today, future visits, procedures, or tests. It is your responsibility to advise this office of your programs requirements in advance, each and every time we provide a service. We will do our very best to comply with any reasonable requirements that your program may have.

3. Fees for services, which include unpaid balances, deductibles and co-payments, are due at the time of service. Returned checks and unpaid balances may be subject to collection placement and collection fees. Additional fees may apply to the following: returned checks, completion of disability or other forms, and copying of medical records.

4. All charges are your responsibility whether your insurance company pays or does not pay. If your insurance carrier does not remit payment within sixty days, the balance will be due in full from you. If any payment is made directly to you for services billed by Your Natural Dr LLC and Dr Michelle Hessberger, you recognize an obligation to promptly remit payment to Your Natural Dr LLC.

5. I understand and agree that if I fail to make any of the payments for which I am responsible in a timely manner, then appropriate collection measures may be initiated. I also understand that after such default and upon referral to a collection agency or attorney by Your Natural Dr LLC, I will be responsible for all costs of collecting monies owed, including court costs, collection agency fees, and attorney fees.

6. I am aware that some of the services I may receive may be non-covered or not considered reasonable or necessary by Medicare, Medicaid or other insurers. An example is acupuncture. Payment for these services must be paid at the time of the visit if not covered by insurance.

The office of Your Natural Dr LLC and Dr Michelle Hessberger understands that financial problems may affect timely payment, so we encourage you to communicate any such problems to us, so that we may assist you in keeping your account in good standing. If you have any questions, please call us at 203-549-1511.

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P. 203-549-1511 F. 203-690-1522
YourNaturalDR@gmail.com www.YourNaturalDR.com

MISSED APPOINTMENTS: We ask that you provide us the courtesy of 24 hours (1 business day) notice for the cancellation of office visits so that we can fill in those appointment slots with other patients who may be waiting. If you miss your appointment, or do not cancel with the required notice, then additional fees may apply.

ELECTRONIC HEALTH RECORD: Healthcare providers require access to patient medical information whenever or wherever a patient presents for care to assure safety, quality, and to coordinate patient care across the provider network, avoiding duplication of services. Confidentiality of records including those reflecting treatment for behavioral health issues, HIV/AIDS or drug & alcohol problems is maintained per relevant governmental and regulatory standards. Patient medical records are automatically sent to referring providers and primary/family physicians, as well as to physicians who are consulted by the attending physician for coordination of care. Your Natural Dr LLC may furnish and release to federal and state healthcare oversight agencies, or upon written request, to all insurance companies or their representatives any information with respect to treatment of the patient herein named including copies of the medical record.

CONSENT FOR ELECTRONIC COMMUNICATION: I authorize Your Natural Dr LLC, including Dr Michelle Hessberger and assigned office staff, to contact me at the phone numbers I have provided to the office, as well as to leave messages on my voicemail or answering system. This includes messages related to upcoming appointments, notification to call us back regarding test results or other medical issues, and for billing purposes. As a service to our patients, we provide a courtesy Bill Pay Reminder call and possibly other important calls that may be placed using a prerecorded message. By providing your phone number, you consent to receiving such calls at this number.

I, or my legal representative, certify that I have read this document, that it has been fully explained to me and that I understand its contents, and hereby agree to all terms and conditions set forth above and acknowledge the receipt of a copy if requested.

_____ _____

Signature of Patient or Authorized Representative Date

_____

Printed Name and Relationship (ex. self, mother, etc.)

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