HEALINGSPACE
medical center

Payment Policy and Authorization

PAYMENT POLICY: For continuity of care with our practice, we require that all patients maintain a valid credit card in our PCI compliant secure database **[Note: HSA cards cannot be stored but may still be used at visits for payments.]** We understand your concerns with providing us this confidential information, but assure you that this information is kept confidential.

I hereby acknowledge receipt of services, authorize HealingSpace, LLC to bill the credit card I have provided below to keep on file for such services, and agree to take all further actions required to pay the charges in full and to perform the obligations set forth in my agreement with my credit card issuer.

I understand that I am responsible for a $35.00 return fee on all returned checks I issue for any services rendered through HealingSpace, LLC.

In addition to the principle amount or returned fee owed, I agree to pay 50% of the unpaid balance as collection fees if my account is turned over to a collection agency. I further agree to pay reasonable attorney fees and cover costs arising out of any litigation concerning the collection of this account.

I understand that I am entering into a contractual relationship with HealingSpace, LLC and its practitioners for professional care. Patient/guardian acknowledges that he/she has been given ample opportunity to read this agreement and to ask questions about it.

I acknowledge that I have fully read and understand all the terms and conditions, as well as any charges and payment terms associated with this contract, and hereby agree to be bound by all of the above terms.

You expressly consent to be contracted, by HealingSpace LLC/anyone calling on its behalf, for any and all purposes, at any telephone number, or physical or electronic address you provide or which you may be reached, including any wireless telephone number. You agree that HealingSpace LLC may contact you in any way, including calls or pre-recorded or artificial voice or text messages delivered by an automatic telephone dialing system, or email messages delivered by an automatic emailing system. You acknowledge that this consent cannot be revoked without prior agreement and acceptance by us. You agree to promptly notify us at any time of any changes to your contact information.

I have read, understand and agree to this policy and authorization.

Patient/Guardian Signature_____

Printed Name: _____ Date:_____

CREDIT CARD INFORMATION: NO HSA CARDS PLEASE

Name of Patient: Last_____ First_____ MI_____

Name of Cardholder: Last_____ First_____ MI_____

Card Type (circle one): VISA M/C AMEX DISC EXP. DATE: ____/____ CVV #: _____

Credit Card Number: XXXX XXXX XXXX ____ ____ ____ ____ (ONLY THE LAST FOUR DIGITS ARE NEEDED)

Billing Address (Required): _____

Phone Number: _____ Authorized Signature: _____ Date: _____

Employee Initials _____

Revised 4/11/19 dr

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I have specifically sought out the services and perspective of Dr. Marilyn Mitchell for her integrative approach to medicine. I understand that I will be presented with treatment options that include traditional and integrative approaches, and that ultimately, I will make the final decision on which method of treatment is right for me and my family. I understand that I may refuse or stop treatments at any time.

BLUE CROSS BLUE SHIELD PATIENTS: We directly bill Blue Cross for patient accounts as a courtesy. Our billing department will make an effort to work with each patient and the insurance provider to reconcile any payment disputes; however there is a limit to the services we can provide due to the high administrative cost involved. We strongly suggest you monitor your account carefully and call our billing department if any questions arise. We will ensure our best effort to make this a smooth process.

I understand that all charges incurred are the personal responsibility of the patient/guarantor. I authorize payment for services rendered to be paid directly to HealingSpace, LLC, if correct information is supplied at the time of visit, that managed care insurance is filed with the contracted carriers. I understand I am responsible for all residual balances including but not limited to copays, deductibles, coinsurance and charges not paid by insurance carrier for any reason, after consideration of contractual adjustments and give my authorization to charge the credit card on file for any/all outstanding balances owed to HealingSpace LLC.

I will receive three statements and a final notice from HealingSpace, LLC. If no payment is received the credit card information provided below will be processed for my account. **PATIENT INITIALS**_____

AUTHORIZATION TO RELEASE INFORMATION

I authorize HealingSpace, LLC to release any information needed, including the diagnosis and record of any treatment/examination rendered to me or my dependents, to secure payment of benefits. **PATIENT INITIALS**_____

SELF PAY, OUT OF NETWORK and NON- BCBS PATIENTS: Full payment is required at the time of service, HealingSpace, LLC will provide these patients with an encounter form and receipt to submit to their insurance carrier at checkout upon request. We cannot guarantee reimbursement from your insurance carrier.

By signing this form, I understand that it is my responsibility to know the details of my insurance plan/ out-of-network coverage. If for any reason, I have an outstanding balance with HealingSpace Medical Center, I give permission to charge the credit card on file for any/all outstanding balances owed. **PATIENT INITIALS**_____

CANCELLATION POLICY: If you are unable to keep an appointment, we ask that you kindly provide us with a minimum of 24 hour notice. In the event that you are unable to provide such notice, you will incur a no-show or last minute cancellation fee of $50. Our office will accept cancellations during office hours by phone or after hours by email at info@healingspacellc.com if received 24 hours prior to your appointment. This courtesy on your part will make it possible to accommodate other patients. **PATIENT INITIALS**_____

NON MEDICAL SERVICES

Full payment is required at the time of service for any/all non medical services.
These include but are not limited to:

- Energy Healing
- Nutritional Counseling
- Thermography Services
- All Massage and TRE sessions
- Nutritional IV Therapy
- Supplements and retail products

In the case that payment is not collected at the time of service and I have received the service, I give my permission for the card on file stated here after to be charged for the service(s) rendered. I understand it is ultimately my responsibility to ensure I pay for any/all services I receive/schedule with HealingSpace Medical Center. **PT INITIALS** _____

Employee Initials _____

Revised 4/11/19 dr