Nancy E. Boyden, ARNP
7901 Skansie Avenue, Suite 105 Gig Harbor, WA 98335 (253)858-2408 www.gigharborhealthclinic.com

Thank you for choosing Nancy E. Boyden, ARNP for your healthcare needs. Our office is committed to providing our patients comprehensive healthcare that also includes alternative methods. We want you to be informed of our office policies and billing procedure requirements.

Our office is happy to submit insurance claims on your behalf, however we are not responsible for following up with them in the event that there are delays in reimbursement. Insurance companies have 30 days to submit payment once they receive a claim. If no payment is received after 30 days, the fees become patient responsibility. You are required to provide us with your current insurance information and responsible for any copayment and/or co-insurance and any deductibles at the time of your visit. If we are contracted with your insurance carrier, you will only be responsible for the contracted fee. There may be additional problems found during an exam that may be billed separately. Any charges not covered are patient responsibility. We gladly accept cash, check, Visa, Mastercard and Discover.

Some insurance companies do not cover certain alternative procedures as well as certain diagnostic testing. It is your responsibility to check with your insurance company for coverage benefits as any non-covered services are patient responsibility. You will be billed separately by the lab for any bloodwork, pap smears or cultures that Nancy Boyden orders. Please let us know if your insurance contracts with a particular lab so that we may assist in sending your orders to the correct laboratory. Your insurance company may also require that you designate a Primary Care provider (PCP) in order for any referrals to specialists to be covered. This may also be applicable to the amount of co-pay that is due in addition to coverage for preventative and wellness exams.

Assignment of Benefits

I hereby authorize and request my insurance carrier(s) to pay directly to the healthcare provider benefits due on claims for services furnished to me or (my dependent) by this office. I understand that any amount not covered by my benefit, or deemed not a condition of my policy benefit is the patient or guarantor's financial responsibility. I also understand my insurance policy is a contract between my company and me.

Medicare Coverage

Please be advised, that we ***DO NOT*** participate with Medicare. Services related to your care may/or may not be covered, (ie. labs, prescriptions, etc.) Medicare does not reimburse for alternative therapies or services related to alternative therapies. For any services that May Not be covered an Advanced Beneficiary Notice must be signed and completed prior to your appointment.

I have read, and understand the policy and billing procedure requirements outlined above and acknowledge that I, the patient or guarantor, will be responsible for any fees associated with the services provided.

_____ _____ _____

Date Patient (Print Name) Patient Signature (or Legal Guardian Signature)