Statement of Financial Responsibility

I,_____, understand and agree to the following general responsibilities:

- I am responsible as the patient or patient's guarantor for full payment of services rendered at the time of service, including Medicinary, lab work and tests, and physician ordered add-on lab work and tests.
- I am responsible for providing all accurate and thorough documentation required to support any discounts I am receiving.
- I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees.
- I hereby authorize Sirona Integrative Health to release information necessary to secure payment.
- There will be a flat fee of $60 for any office visit OR $100 for any procedure that is either missed or not canceled within 24 hours of the appointment time.

I understand and agree to the following with regards to insurance billing:

- I understand that Sirona Integrative Health does not bill insurance on my behalf and I am expected to pay at the time of service.
- If I have an insurance plan that, I can request a superbill for services rendered to be submitted by me for reimbursement.
- I understand that it is my responsibility to determine whether my insurance company offers reimbursement for services rendered.

Patient Name (print): _____ Provider Name: Dr. Michelle Williams

Patient Signature: _____ Provider Signature: _____ ND