Foundational Wellness
ALTERNATIVE HEALTH
RENO~TAHOE

Financial Agreement

I _____ , _____

(Clients Name) (Social Security Number)

Hereby acknowledge by this statement that full payment is required at the time of service, and that Foundational Wellness does not accept assignment of insurance benefits.

I have been fully informed some, and perhaps all, of the services provided by Foundational Wellness. may be “non-covered” services sand not considered reasonable and necessary under the Medicare program and/or other governmental or private health and medical insurance programs. I realize my insurance coverage, including Medicare, will not pay for such “non-covered” services, and I will be personally, and legally responsible for payment to Foundational Wellness for such “non-covered” services, including any costs of collection, including attorney fees.

I am aware Foundational Wellness is not a Medicare provider and does not bill Medicare, but can provide a superbill, upon request, to submit to my private insurance company for reimbursement of services rendered. I understand I am still responsible for payment of all services at the time they are given. I do authorize release of any information to my insurance company or any other third party acting on my behalf, which may be needed to process my claim including my medical, personal, financial and insurance information that I have provided to Foundational Wellness.

I understand and agree Foundational Wellness may not provide services unless and until all amounts due and owing by me are paid in full.

Clients Name: _____ Date: _____

(Please Print)

Clients Signature: _____