Shekinah
HEALTH & WELLNESS CENTER

325 Clyde Morris Blvd Suite 430, Ormond Beach, Fl 32174
Phone: 386-206-2929 | Fax: 386-951-3312
Email: totalcare@shekinahealth.com

Patient Financial Responsibility Form

Patient's Name: _____ Guardian (If minor): _____

Phone Number: _____ Email: _____

Address: _____

Thank you for choosing Shekinah Health & Wellness to help you achieve optimum health. We are happy to work with you whether you have an insurance carrier or paying cash for your services. Please review the below to help us assess your financial responsibility for the services that are being provided to you.

General financial consent (Please check each box to give consent)

☐ I acknowledge and attest I have sought evaluation, treatment, or medical advice from the staff Shekinah Health & Wellness Center and its partners.

☐ I consent that Shekinah Health & Wellness Center can keep my credit card information on file for future billing and payments.

Please select the most appropriate base on your financial situation:

☐ I acknowledge that I do not have insurance and will pay cash; therefore, assuming full financial responsibility for all services rendered to me.

☐ I am authorizing the services I received to be processed through my insurance ONLY to help contribute toward my deductible or out-of-pocket maximum. I will pay cash for all services until my deductible or outpocket maximum is met.

☐ I have and will use my health insurance to pay for all medical services.

*NOTE: If you are a completely cash-pay patient and don't have or aren't utilize an insurance payor, please skip to the signature section. Please complete the **Authorization to Bill Insurance Form** if we are billing your medical services through your insurance carrier.*

Authorization to Bill Insurance

We are happy to work with your insurance carrier to ensure you receive your health and wellness services at the appropriate cost covered by your policy. Please be aware that insurance quotes are an ESTIMATE only. Coverage may be different if your deductible and/or annual maximum has not been met, or if your coverage table is lower than average.

	Name of Insurance Company	Policy Number
Primary Carrier Information		
Secondary Carrier Information		
Supplemental Carrier Information		

To ensure you fully understand our insurance claims processing and billing policy, please read and check each box below to provide your consent:

☐ I authorize Shekinah Health & Wellness medical staff to release me or my minor child's medical information to the insurance company listed above for the purpose of determining my medical benefits and receiving benefits for my or my minor's medical bills

☐ I will be held responsible for any amount of my medical bills not covered by my insurance policy or claims including any **deductibles, co-payments, and co-insurance and any necessary fees.** Any portion of my medical bills not covered by insurance will be billed to me at the address I have provided above.

☐ I am responsible to pay all co-payments and/or co-insurance at the time of service, prior to leaving the office.

☐ If my insurance determines that I have not met my deductible, I understand that I will be fully responsible for payment in a timely manner, no more than 30 days after I have been notified by insurance or Shekinah Health and Wellness Center.

☐ I understand that non-compliance or defaulting on payments may result in denial of service, submission to a credit bureau and/or a legal claim against me for non-payment.

Signature

Whether I am a self-pay patient and/or processing my services through an insurance carrier, I assume full financial responsibility for services rendered to me.

_____ _____

Patient/ Guardian Signature Date