

**Patient Acknowledgement of Financial Responsibility**

I, \_\_\_\_\_ hereby acknowledge full responsibility for the payment of services and agree to pay for these, in full, at the time of service. I understand that there is a 72-hour cancellation policy and agree to pay the 50% cancellation fee for any cancellation with less than 72-hour notice. I understand that payment for 50% of the cost of the appointment is due at the time of scheduling.

Center for Integrative Medicine will attempt to fill cancelled appointments and if successful, there will be no fee. Therefore, providing us with as much notice as possible will help us to accommodate your changes.

I understand that some or all of the services provided by Center for Integrative Medicine, on or after this date, by Drs. Derek Abbassi, Sara Gottfried, Marsha Nunley, and/or Charlotte Massey, ND, LAc, may not be covered by my health insurance plan or Medicare. I understand that Medicare does not reimburse for supplements nor are Dr. Gottfried or her Associates Medicare-participating physicians. I understand that a superbill will be provided with my diagnostic codes that I may submit to my insurance for potential reimbursement. I understand that some insurance companies may reimburse for a percentage of the laboratory tests and professional fees but it is possible that the services provided by my doctor may not be reimbursable. It is my responsibility to check with my insurance company about their policy.

I understand that if I need my chart copied for any reason, I will be charged a \$35 fee.

Patient Signature \_\_\_\_\_ Date \_\_\_\_\_

Parent or Guardian's Signature (if relevant) \_\_\_\_\_