Date Completed: _______________

MRN: _________________________

DOB: __________________________

Main Campus: 3025 SW Corbett Ave. Portland, OR 97201
NUNM Information Center: 503-552-1551

FINANCIAL POLICY

At NUNM our policy is to collect payment for all services rendered at the time of service. Patients who are not able to pay or who have not made arrangements with our billing office may be required to reschedule their appointment. Patients may also receive a bill for additional services rendered, such as in-house labs and procedures ordered during an office visit, if the insurance company adjusts the bill, or if new information is acquired bringing about new charges. These bills are non-negotiable.

FOR ALL PATIENTS:

- There will be a flat fee of $20 for any appointment that is either missed or not canceled within 24 hours of the appointment time.
- You acknowledge that you are financially responsible for all charges. Any account over 120 days old will be sent to collections. 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. You hereby authorize the NUNM Health Centers to release information necessary to secure payment.
- You are 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, as well as any physician ordered add-on lab work and tests.
- Refund Policy: We will issue a refund of any credit on an account 30 days from the issue of the credit to the account. Refunds are issued by check and mailed to the address on the guarantor account.

TIME OF SERVICE AND OTHER DISCOUNTS:

- If you apply and qualify for any discounts, you are responsible for providing accurate information for all required documentation within 30 days.
- As a courtesy of paying in full at the time of service, you will receive medical services at a discounted rate. If you do not pay at the time of service your account will not reflect a time of service discount.
- Discounts through our Compassionate Care program may be extended to you based upon the gross annual income information you provide.

IF YOU ARE INSURED:

- You authorize release of information in your medical history to your insurance carrier and assign all benefits for unpaid services to the NUNM Health Centers. This release applies to support of the insurance billing process only.
- The pre-verification by NUNM of your health insurance is used to determine if there is coverage for services through your insurance and is NOT a guarantee of payment by your insurance.
- You are responsible for providing all accurate and thorough documentation required to verify your insurance coverage and / or bill your insurance carrier.
- You understand that the NUNM Health Centers can require proof of insurance at any time and that your insurance may need to be re-verified for specific coverage details as often as every 6 months, if there is a denial of a claim, or if you have a change in coverage.
- You are responsible for full payment of all insurance co-pays, deductibles, and co-insurance balances due, including any and all services not covered or paid by your insurance carrier at the time of service.
- You are responsible for payment even if your insurance company makes a determination that the care received was not medically necessary.

Continued on backside

Rev. 10.10.19 BL

Date Completed: _______________

MRN: _________________________

DOB: __________________________

Main Campus: 3025 SW Corbett Ave. Portland, OR 97201
NUNM Information Center: 503-552-1551

- You may forfeit the privilege of billing your insurance carrier if you do not comply with any of your financial responsibilities or documentation requirements.
- You understand that NUNM Health Centers will not bill motor vehicle insurance.

MINORS SEEKING TREATMENT WITHOUT A PARENT/GUARDIAN (AGES 15-17):

I, ______________________________, certify that I am ________ years old. I am seeking outpatient health services from the National University of Natural Medicine (NUNM). I have been fully informed of the services to be rendered and consent to those services.

Payment Method – Choose One and Initial

1. _________ I agree to allow NUNM to notify my parent(s)' to the extent necessary to obtain insurance coverage for the services provided:

   My Insurance Information is as follows:

   Insurance Company ____

   Policy # ____

   My parent(s)' mailing address and phone number are as follows:

   Phone: ____

   Address: ____

   ____

2. __________ I do NOT want NUNM to notify my parent(s)' regarding any of these services unless required by (initial if yes) law to do so. I do not wish that NUNM obtain my parent(s)' consent to bill insurance. I fully understand that NUNM requires me to pay for all services in advance and that my failure to do so may result in termination of services. In the event that I am unable to pay for these services, NUNM may, at its sole discretion, terminate this relationship and refer me to appropriate health providers.

I have fully read, understand, and agree to these financial policies.

____

Patient (15 years or older) Date

____

Parent, Guardian, Responsible Party Date