GEM
Integrative Wellness

Dr. Galina Mahlis, ND

Statement of Financial Responsibility

I, _____(or the patient named below for whom I am legally responsible), understand and agree to the following financial responsibilities pertaining to all my visits with Dr. Galina Mahlis, ND:

I am responsible as the patient or patient's representative for full payment of services at the time of the visit, including any supplements, products, or additional pertinent fees. 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, I agree to pay all costs and expenses, including reasonable attorney fees. I hereby authorize Dr. Galina Mahlis, ND to release information necessary to secure payment.

I understand that there will not be an additional fee for missing a scheduled visit without notice, but I will try my best to inform the doctor at least 24 hours in advance if I need to cancel an appointment.

I understand and agree that my doctor practicing naturopathic medicine operates as a cash-based practice and does not accept any form of insurance. A superbill will be provided per visit with all necessary information in order for the patient to submit for insurance reimbursement. Dr. Galina Mahlis, ND is not responsible for ensuring insurance reimbursement.

I have fully read and understand the above agreements and authorizations.

_____ _____

(Patient/patient's representative signature) (Date)

Indicate relationship if signing on behalf of patient: _____

_____ _____

(Printed name of patient/patient's representative (Date)