LAKE NATURAL MEDICINE

Dr. Gregory L. McDonald, ND, LAc
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Financial Agreement/Receipt of Privacy Practices

Patient Name: _____ DOB: ___/___/___ Date ____/_____/_____

Responsible Party (if patient is a minor) _____

Financial Policy:

Dr. Gregory L. McDonald, ND, LAc is not a preferred or in-network provider on any insurance plan currently. As a courtesy, our office will bill out-of-network services for most insurances. We may request payment in full at time of service, depending upon your coverage.

Patients should contact their insurance companies directly for any coverage questions. **Your plan may or may not cover naturopathic services or acupuncture, and it is your responsibility to verify coverage.** Co-pays and deductibles usually apply to office visits and treatments performed. If the insurance company denies payment or only pays a portion of the medical bill, you will be responsible for payment of the remaining balance. Your policy is a contract between you and your insurance company, and we cannot guarantee payment of claims.

Our office does not accept Medicare, Medicaid, the Oregon Health Plan, or Worker's Compensation.

Please INITIAL that you have read and understand the items below that apply to you:

____**Patients paying out of pocket (Private Pay):** Payment is due in full at the time of service. We accept major credit cards, checks or cash. If paying by check, we may require your driver's license.

____**Patients paying with insurance:** Patients are asked to bring their current insurance identification card to each appointment. If your insurance information changes, you are responsible to notify us prior to receiving service. Co-payments are due at time of service. Patients are responsible for paying insurance deductibles, co-insurance, and any services not covered by insurance.

____**Patients with auto injury insurance:** Our office will bill your auto insurance claim. You will be responsible for any remaining balance incurred for services beyond the coverage of your PIP (Personal Injury Protection). We may arrange to carry a balance forward until settlement is received and request direct payment from your attorney, should you have one on the case.

Patient or Responsible Party Signature_____

Receipt of Privacy Practices:

My signature below indicates that I have received, reviewed, and/or been offered a copy of my physician's Notice of Uses and Disclosures of Protected Medical Information (*Notice of Privacy Practices*).

Patient or Responsible Party Signature_____