Advanced Integrative Healthcare
William Epperly, M.D.
245 S. Gary Ave. Ste. 207 Bloomingdale, IL 60108

PLEASE READ AND CHECK OFF THAT YOU UNDERSTAND AND AGREE TO OUR OFFICE POLICIES.

□ I will not wear any scented products (hair products, cologne, lotions, etc.) to the office.
□ I will not use email to convey personal health care questions or problems.
□ I am here because I know my health is not what it could be. **I am ready to make Lifestyle Changes** in order to feel better.
□ As a recipient of medical care I, the undersigned, am responsible for all charges regardless of my circumstances for reimbursement**.** Outstanding patient balances may be charged to my credit card on file if not paid **within 2 weeks** of adjudication. I understand a bill will be sent to me when a balance is due and I have 2 weeks to pay or dispute the balance.
□ Advanced Integrative Healthcare (AIH) will bill **only contracted primary** insurances and will comply with the terms of those contracts**. It is my responsibility to know if my insurance is in network or out of network with Dr. Epperly, as well as the terms of my plan.**
□ AIH will not bill secondary insurances or third parties (accident, work comp, etc.).
□ Any claim over 3 months old will automatically become the responsibility of the patient regardless of insurance status.
□ I will provide AIH with **complete and accurate insurance information** including a current insurance card and be responsible for any insurance denials resulting from inaccurate information.
□ In the case of divorce, the parent who is the insurance guarantor will receive any bills. Parents are expected to work out payment arrangements with each other and not involve AIH in any disputes.
□ Patient balances are due in 2 weeks once insurance has made their final determination of the claim.
□ There will be a **$35.00 service charge for any returned check or declined credit card charge**. If I default on my account and the balance is referred to a collection agency or attorney, I will be responsible for all costs of collecting monies owed, including interest, court costs, collection agency and attorney fees.
□ There will be a **$5.00** late fee for any balance that is 15 days past ins adjudication.
□ There will be a **$40.00** no-show fee for appointments missed or not cancelled within 24 hours.

UNIVERSAL CONSENT

□ I understand that by presenting myself for health care services, I consent to basic medical care provided by AIH.
□ I understand that the practice of medicine is not an exact science and there are no guarantees as to the diagnosis or result of examination or treatment in this office.
□ I authorize the release of medical records or financial information **that I request** to be forwarded to me, my insurance company, or another medical facility. I understand that there may be a fee for this service.
□ I understand that a copy of "Patient's Bill of Rights", the Health Privacy Notice, and this financial policy are available on the AIH website or may be obtained from our office upon request.

I give permission for my (or my dependent's) medical information to be communicated with myself and the following people:

1_____ 2 _____

□ I have read and agree to the office policies, financial agreement, and universal consent as outlined.

X_____ _____
Patient / Parent/Legal guardian Date