

Leah McNeill, ND
Ohana Wellness Center
2310 130th Ave NE | Suite B-103 | Bellevue, WA 98005

PATIENT INFORMATION

Name: _____ Today's Date: ____ / ____ /20 ____

Birth Date: _____ Sex: _____

Marital Status (circle one): Single Married Divorced Widowed Separated

Address: _____

City/State: _____ Zip: _____

Home Phone: _____ - _____ - _____ Work Phone: _____ - _____ - _____

Email address (please print clearly): _____

Employer: _____

Primary Care Provider (Dr.'s name): _____

Referred by: _____

In case of emergency, notify: _____ Phone: _____

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Insurance Information: **WE NEED TO MAKE A COPY OF YOUR INSURANCE CARD**

Your relationship to the Insured (subscriber) on the card: _____

Name of Insured: _____ Birth Date of Insured: _____

Employer of Insured: _____

Patient Signature (parent/guardian if minor): _____

Copy of Insurance Card

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PATIENT RESPONSIBILITY AND INSURANCE INFORMATION & VERIFICATION

In order for us to provide optimum service to our patients, it is your responsibility to contact your insurance company to verify your insurance coverage for Naturopathic care. Changes to your benefits can occur between office visits. **You should be sure your insurance is viable for each visit.**

PLEASE BRING THIS FORM, FILLED OUT, TO YOUR FIRST OFFICE VISIT – Do NOT mail / fax it.

Date you called insurance company: _____ Person you spoke with: _____

Primary Insurance Company: _____ Telephone: ____ - ____ - _____

Address to send Claims: _____

Your Name: (print) _____ Your Birth Date: _____

Name of Subscriber: (print) _____ Your relationship to Subscriber: _____

ID# of Subscriber: _____ Birth Date of Subscriber: _____

Employer of Subscriber: _____ Group #: _____

It is your responsibility to call your Insurance Company and ask the following questions:

Is there coverage for Naturopathic care? Yes No

Is Dr. Leah McNeill contracted as a Preferred Provider? Yes No

If NO, is there coverage for non-contracted providers payable at lessor % after deductible met? Yes No

Is a referral from Primary Care Physician needed? Yes No

What are my Lab benefits? Some of the labs used by the doctor include:

Pacific Physicians Lab --- 425-774-3751
Diagnos-Techs, Inc. --- 800-878-3787
Genova Diagnostics --- 800-522-4762

Some labs offer discounts for prepaid labs if no insurance coverage.

It is your responsibility to find out if your insurance is contracted for lab work ordered by the doctor.

I understand that all lab test fees are determined by the lab, and if not covered by patient's insurance, becomes the responsibility of the patient.

Secondary insurance company billing is the patient's responsibility unless doctor is contracted with the secondary insurance company.

Patient signature (parent/guardian if minor): _____

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PAYMENT POLICY / CANCELLATION POLICY

IF NOT COVERED UNDER THE PLANS LISTED BELOW, PAYMENT IN FULL IS DUE AT THE TIME OF SERVICES.

It is then your responsibility to submit claims to your insurance plan for reimbursement of the office fees. This office and your insurance card/company will provide you with the information necessary.

THIS OFFICE SUBMITS CLAIMS TO ONLY THE FOLLOWING CONTRACTED INSURANCE COMPANIES FOR DR. LEAH MCNEILL. SUBMISSION OF A CLAIM IS NO GUARANTEE THAT YOUR INSURANCE WILL PAY.

- Regence ▪ Premera Blue Cross ▪ Lifewise ▪ Aetna ▪ Cigna ▪ First Choice
- United Healthcare ▪ Uniform Medical ▪ Great West

Naturopaths are not always covered by all plans of the above-named insurance companies.

Call the Customer Service Phone # on the back of your insurance card to check your benefits before your first visit.

IT IS YOUR RESPONSIBILITY TO KNOW THE TERMS OF YOUR COVERAGE FOR EACH VISIT INCLUDING:

1. Whether Naturopathic services are covered.
2. If there is a deductible to meet first.
3. Is a referral required from your primary care provider? If yes, it is your responsibility to obtain the referral and provide our office with a referral number before your appointment.
4. If you have a co-payment, it is due at the time of services.
5. If lab tests are covered – both the test itself and the facility used are separate practices and bill separately. It is your responsibility to give your insurance info to the labs.

We **try** to give courtesy reminder calls for appointments 1 – 2 days in advance. However it is responsibility to be aware of your appointment date & time.

**We require 24-hour cancellation/reschedule notice or a \$50.00 fee will be charged.
Missed appointments with no notification will be charged full fees for the appointment.**

YOU ARE DIRECTLY RESPONSIBLE FOR PAYMENT OF ALL CHARGES INCURRED UNDER OUR CARE.

**All Pharmacy items are to be paid for when they are received.
We accept payment by cash, check, Visa, MasterCard, and American Express
We charge \$20.00 for returned checks.
We charge \$10.00 fee/month for patient balance portion not paid within 30 days.
We charge \$50-\$75 for phone consultations (Insurance companies do NOT reimburse for this service.)**

I understand that I am responsible for my account balance with Ohana Wellness Center doctors.
I authorize release of information to all my insurance companies if requested.
I authorize my doctor to help me obtain payment from my Insurance if she is contracted.
I authorize payment direct to my doctor from my Insurance.
I understand that I am responsible for my account balance with facility used for any lab work.
I permit a copy of this authorization to be used in place of the original.

I understand and agree to the above policy. I will abide by its terms.

Name (printed): _____ **Date:** _____

Signature: _____