

Varnam Family Wellness Center, LLC
712 Village Road, Suite 104
Shallotte, NC 28470
Phone (910) 754-CARE
Fax (910) 754-2254

ACKNOWLEDGEMENTS

1. Payment is expected when services are rendered. We accept Mastercard, Visa, American Express, and Discover.
2. I understand that insurance companies require that the practice collects the appropriate copayment or deductible at the time of each office visit.
3. All returned checks for NSF (non-sufficient funds) and/or closed accounts, will pay the cost of the amount owed, plus an additional \$35.00 for bank fees.
4. I authorize use of this form on all my insurance submissions.
5. I authorize release of information to all my insurance carriers.
6. I understand that I am responsible for my bill.
7. I authorize my nurse practitioner to act as my agent in helping me obtain payment from my insurance carriers.
8. I authorize payment directly to my nurse practitioner.
9. I permit a copy of this authorization to be used in place of the original.
10. Accounts with a remaining balance after insurance has been adjudicated [paid, applied to deductible] after 90 days, will be referred to Green Flag Profit Recovery Transworld Systems. A referral fee will be added to your account.

INSURANCE

We will assist you in filing claims in every reasonable way, but please remember that your insurance represents a contract between you (or your employer) and a health insurance company. We will always look to you in our dealings and ask you to deal on your own behalf in disputes with your insurance carrier.

Please be sure to provide us with complete details regarding your coverage and filing requirements and advise us of any changes. Your cooperation is necessary in filing claims for you.

We will do everything possible to assure that you receive full benefits from your insurance policy, but, if for some reason your insurance company has not paid their portion within 60 days from the start of treatment, you are responsible for payment at that time. Any balance remaining due after insurance payment has been received will be billed and due within 30 days.

SIGNATURE ON FILE

By signing below, I do hereby state that I have read and understand these acknowledgements and will adhere to these terms and conditions.

Patient Signature and/or Guardian

Date

Witness

Date

VARNAM FAMILY WELLNESS CENTER, LLC
"RED APPLE PROFESSIONAL PARK"
712 VILLAGE ROAD, SUITE 104
SHALLOTTE, NC 28470
PHONE (910)754-2273
FAX (910)754-2254

INFORMATION RELEASE FORM

Social Security Number _____

Date of Birth _____

I, _____, give my permission to Varnam Family Wellness
Center to:

- 1) Leave message on my answering machine at home. YES NO
- 2) Leave a message at my place of employment. YES NO
- 3) Mail lab / pathology result to my home address. YES NO

Address: _____

- 4) Discuss my medical condition with any member of my household. YES

If yes, whom: _____ Relationship: _____
_____ Relationship: _____

Patient Name: _____

Signature of Patient or Responsible Party: _____

Witness: _____

