**Patient Financial Agreement**

**1. INDIVIDUAL’S FINANCIAL RESPONSIBILITY**

* I understand that I am financially responsible for my health insurance deductible, co-insurance or non-covered service.
* Co-payments are due at the time of service.
* If my plan requires a referral, I must obtain it before my visit otherwise I will be liable for the charge incurred at the time of the visit.
* If my health plan determines a service to be “not payable,” I will be responsible for the complete charge and agree to pay the costs of all services provided.
* If I am uninsured, or Green Health Collective does not participate with my insurance, I agree to pay for the medical services rendered to me at the time of the service.

**2. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS**

* I hereby authorize and direct payment of my medical benefits to Green Health Collective, LLC on my behalf for any services furnished to me by the providers.

**3. AUTHORIZATION TO RELEASE RECORDS**

* I hereby authorize Green Health Collective, LLC to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

**Signature of Patient, Authorized Representative, or Responsible Party**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_