Services not Covered by Insurance, Patient Signature Page:

PATIENT UNDERSTANDING AND AUTHORIZATION

I have read page one of this document. I understand that my insurance company will likely not pay for all of the services I receive in your office, particularly the services listed above. I agree to be personally and fully responsible for payment of such fees. I understand that, if I choose to appeal to my insurance company for any services that they denied, I may not depend on any further documentation from your office. In any instance that Three Rivers Ayurveda (TRA) may agree to writing a report to "justify" the charges, there will be a charge to me for that report. I understand that as part of my treatment in this clinic, I may or may not receive any or all of the treatments and services listed herein.

Date: _____

Signature of patient or person acting on patient's behalf:

_____

Printed name of patient or person acting on patient's behalf:

_____

Note: Your health information will be kept confidential. If a claim is submitted to your insurance company, your health information may be shared with that company.