Total Health Center Inc.
1018 North Avenue
Battle Creek MI 49017
(269) 968-0888

I, the undersigned, do hereby agree and give consent for Total Health Center Inc. to furnish medical treatment in which is considered medically necessary and proper in evaluation and treatment of my physical condition.

PLEASE PRESENT INSURANCE CARD (s) TO RECEPTIONIST.

In order to establish optimal relations with our patients and avoid misunderstanding regarding our payment policies, our staff is trained to inform you of the financial policies of this office. PAYMENT IS EXPECTED FROM YOU, AT THE TIME OF SERVICE, FOR "YOUR PART" OF THE CHARGES. WE ACCEPT CASH, CHECK, VISA and MASTERCARD FOR YOU CONVENIENCE.

If you need to cancel an appointment, we require a 24 hour notice. If you cancel with less than 24 hours notice for your appointment, a $25.00 fee **will** be billed directly to you, which the **fee will be due at your next visit.**

I am an eligible member as of this date of service of a health plan and a copy of the benefit card is attached to this document. Signature of responsible party below acknowledges full financial responsibility for services rendered to me, including costs, if it is determined that I am "not eligible" on the date of service in question or if service rendered is determined to be a non-covered benefit under the plan provisions.

I understand and agree that if I fail to make any of the payments for which I am responsible for in a timely manner, I will be responsible for all costs of collecting monies owed. These fees may include court costs, collection agency fees and attorney fees. Interest fees of 2% monthly on the unpaid balance if more than one statement is sent without receipt or payment arrangements made.

Your signature below indicates that you understand and accept this policy. Your signature authorizes Total Health Center Inc. to release such medical information necessary to process your insurance claims (if any). You herein authorize payment of medical benefits to Total Health Center Inc. when an assigned claim is filed.

I give consent to leave a message on my answering machine or voice mail ☐ Yes ☐ No
I give consent to leave a message and/or discuss my medical condition with any member of my household. ☐ Yes ☐ No
If yes, whom: _____ Relationship: _____
HIPAA Password for account _____ Email Address:_____
Emergency Contact _____ Phone #: _____

_____ _____
Patient/Guarantor Signature Date

_____ _____
Total Health Center Inc. Representative Date