ACKNOWLEDGEMENT OF PAYMENT AND CANCELLATION POLICY

I. Payment

By my signature below, I understand, acknowledge, and agree that I am fully responsible for payment of services provided to me by Elev8 MD Wellness Center and that payment must be made in full by cash, check, or credit card at the time of service. Returned checks will be subject to a $50 nonsufficient funds fee.

I understand that treatment and services provided by Elev8 MD Wellness Center may not be covered by my insurance. Elev8 MD Wellness Center does not contract with any insurance plan. Elev8 MD Wellness Center will provide information to me to assist me in my claim for reimbursement to my insurance carrier but will not submit claims to insurers on my behalf. This includes Medicare and Medicaid plans. **If I have Medicare or Medicaid, I agree to disclose that information to Elev8 MD Wellness Center.** In that event, I agree to complete the Advance Beneficiary Notice of Non-coverage form provided to me. I further acknowledge and agree that if I choose to submit any bill or itemized receipt to an insurance carrier for reimbursement for these services, that Elev8 MD Wellness Center is exempt from any dispute regarding reimbursement. I fully agree and acknowledge that Elev8 MD Wellness Center is exempt from ALL claim issues regarding Medicare and Medicaid.

II. Cancellation

To fairly and effectively serve patients who wish to receive treatment, the following cancellation policy has been implemented. By your signature below you acknowledge and agree to the following cancellation policy:

One hour infusions must be cancelled at least 72 hours in advance. One-hour infusions cancelled less than 72 hours in advance will incur a full $425 charge, that will need to be settled prior to re-booking the appointment. This is in ADDITION to the cost of any subsequent appointments.

Two hours, or more, infusions must be cancelled at least one week in advance. If cancelled less than policy stated, then 50% of total service charge will be owed prior to re-booking the appointment. This is in ADDITION to the cost of any subsequent appointments.

Patient or Legal Representative Signature ____

Print Patient or Legal Representative Name : ____________________________________

Elev8 MD
WELLNESS CENTER

Date_________________