Crest Health and Wellness, LLC
1410 Forum Katy Parkway, Suite 101
Columbia, MO 65203
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Office Policies:
Notice of Insurance Practices and of Patient Financial Responsibility

By signing this form, I acknowledge that, with respect to services rendered by Dr. Adriana McGarity, Crest Health and Wellness, LLC, and their employees and agents (collectively "the Practice"), I understand the following.

General Office Policies

Appointments. When calling the Practice for an appointment or setting up an appointment on the Practice's web portal or application, please provide your name, date of birth, phone number, chief reason for visit, and any updated contact or insurance information. Please be on time. Please bring your photo ID and insurance card (if relevant) and payment means to every appointment.

Appointment Notice and Cancellation Fee: The Practice requires at least 48 hours advance notice prior to cancellation of any scheduled appointment. If you miss your scheduled appointment, or cancel with less than the above advance notice, the Practice will charge to your credit card a cancellation fee of half the appointment fee for the first visit or the full fee for subsequent appointments. You hereby authorize this charge by providing the information in the Practice's electronic client portal.

Return of Products: Products returned within 14 days of purchase that are unopened and in resalable condition (at the sole discretion of the Practice) may be returned for credit against future purchases, less a 15% re-stocking fee. No cash refunds are given. Products after this time will not be accepted.

Specialty Laboratory Testing: Our clinic frequently uses functional medicine specialty laboratory testing. These are usually an out-of-pocket expense. Occasionally, there is some insurance coverage depending on the insurance company and plan you have. We will notify you of the costs associated with specialty labs before ordering them.

Online and phone communication; Electronic signatures. The Practice stores medical and office records digitally. While the Practice makes reasonable efforts to keep the data secure according to legal requirements, and maintains the privacy and confidentiality of patient data, I understand that no system is 100% secure. I agree that electronic signatures below are the legal equivalent of manual signatures on this Agreement, and manifest consent to be legally bound by this Agreement's terms and conditions.

Office Insurance Practices and Patient Financial Responsibility

Payment: The Practice accepts cash, check and various credit cards. The Practice bills to my debit or credit card on file unless you provide alternate payment information and instructions.

No Participation in Insurance Plans: The Practice is an out-of-network provider for services within this practice; the Practice does *not* participate in *any* insurance panels and does not accept assignment from any

insurance company. Consequently, I am responsible for payment in full at time of service and charges are determined by the Practice.

No Responsibility To Determine Eligibility for Benefits: The Practice is not responsible for determining eligibility for benefits or for assisting me with collecting insurance benefits and has no responsibility to correspond with or telephone or email any insurer with which the Practice is an out-of-network provider.
My Financial Responsibility: The Practice may provide me with an itemized statement (or "super-bill") to present to my insurance carrier. However, I am financially responsible for any charges for services even should my insurer determine that those services are non-covered or are unreasonable, medically unnecessary or inappropriate. I also agree to be responsible for costs and expenses, including court costs, attorney fees and interest, should it be necessary for the Practice to take action to secure payment of an outstanding balance.

Medicare: **THE PRACTICE DOES NOT ACCEPT MEDICARE OR MEDICAID PATIENTS. IF YOU ARE A MEDICARE OR MEDICAID BENEFICIARY OR WILL BE ELIGIBLE FOR MEDICARE OR MEDICAID WITHIN THE NEXT 12 MONTHS, PLEASE NOTIFY THE PRACTICE IMMEDIATELY.**

Charges: In addition to the office consultation fee, the Practice may also charge me for specific services such as blood or urine tests, ultrasound, office surgical supplies and procedures, blood drawing and handling, and in-hospital services. The Practice often recommends testing through a specialty lab for information that cannot be tested through a conventional lab. This is one of the ways to dig more deeply into what may be causing or contributing to symptoms. I understand that the Practice cannot guarantee that recommended lab testing (through a conventional lab or specialty lab) will be covered. It is my responsibility to check with my insurance company prior to getting any recommended lab work done to check on coverage.

I have carefully read this form, which is printed in English, and acknowledge that English is a language I read and understand, and that I understand the form. I do not feel rushed or impaired, nor am I under the influence of a sedative or sleep-inducing medication.

I accept and agree to all of the terms above. I am free to refuse or withdraw my consent and to discontinue participation in any treatment, service, or research at any time without fear of reprisal against or prejudice to me. No representations, statements, or inducements, oral or written, apart from the foregoing written statement, have been made. I may request and receive a copy of this form from the Practice. If any portion of this form is held invalid, the rest of the document will continue in full force and effect.