



Augusta B. Swift, N.D.
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Dear New Patient,

Welcome to our clinic. We look forward to providing for your health needs. We encourage your questions and participation in all aspects of your health care.

Please read and initial the following:

_____ **Payment for all medicinal items is due at the time of the visit.**

Initials

1. **Augusta Swift, N.D. is a network provider on a few insurance plans. If you have a plan that covers her services, we will bill your insurance directly. You will only be responsible for your co-pay.**
2. **If you do not have insurance coverage, you will receive a 20% day of service payment discount. Dr. Swift is willing to bill your insurance in the case that she is not a network provider, although you are personally responsible for the total amount that is owed to Augusta B. Swift, N.D. in the case that your insurance company does not cover entirely.**
3. **Assignment of Benefits. You request that payment of authorized insurance benefits be made on your behalf to Augusta Swift, N.D. for any services provided to me by Augusta Swift, N.D.**

_____ Initials

You will be charged a Missed Appointment fee of \$50.00 for any missed appointments or late cancellations (less than 24 hours notice).

_____ Initials

I give permission for the staff and Dr. Augusta Swift to contact me via telephone or email and leave a message that may contain appointment or medical information if I am not available.

_____ Initials

I consent to services rendered and provided to me by Augusta B. Swift, N.D. while assisting in my care.

_____ Initials

As the patient, you are responsible for the total charges incurred for each visit. We accept MasterCard, VISA, Debit cards, checks, and cash. There will be a charge of \$20.00 for every returned check(s). We do arrange payment plans.

You recognize, understand and agree that Dr. Augusta Swift is a sole practitioner and is not a partner or otherwise affiliated with any other health care provider who may be providing similar services at the Vital Health and Wellness. You further recognize, understand and agree that Dr. Augusta Swift is solely responsible for and shall provide all professional services to you, and you are relying solely on Dr. Augusta Swift's skill for the professional services rendered at Vital Health and Wellness.

Dr. Augusta Swift may prescribe medication, which may be purchased either at Vital Health and Wellness or elsewhere. Most insurance companies do not cover the pharmacy items that we prescribe and dispense.

I have read and understand the above-stated policies of Augusta B. Swift, N.D. and will comply with them in all respects. If my insurance company requires release of my medical records, I hereby give my permission by signing this form.

Your Signature (parent signature if minor)

Print your name (parent name if minor & patient name)

Date