



NON-INSURANCE BILLING ACKNOWLEDGMENT

Patient Name: _____

DOB: _____

Date: _____

Purpose of This Acknowledgment

Integrative Medicine & Wellness provides a range of specialized wellness and elective services. Some of these services may be covered by certain insurance plans; however, our practice does not bill insurance for the services listed below, regardless of potential coverage. This form confirms that you, the patient, understand and agree to these billing policies.

Services Not Billed to Insurance

By signing this form, you acknowledge that you are fully responsible for all costs associated with the following services, which will not be submitted to insurance by Integrative Medicine & Wellness:

- Annual Fee
- Hormone Consults / HRT Compounding
- Hormone pellet therapy (pelleting)
- Peptide therapies
- Nutritional supplements / Nutraceuticals
- IV therapy / infusion services
- Weight-loss management services or programs / GLP-1s

You understand that:

- These services are self-pay only.
- Payment is due at the time of service unless other arrangements have been made.
- You may independently submit receipts to your insurance provider, but Integrative Medicine & Wellness will not communicate with insurance companies, provide billing codes, or complete insurance forms for these services.

Patient Acknowledgement

I acknowledge that I have read and understand the above information. I understand that the services listed are not billed to insurance by Integrative Medicine & Wellness, even if my insurance plan might otherwise cover them. I agree to be personally responsible for all charges related to these services.

Patient Signature

Date

Practice Representative (optional)

Date