Evolutionary Healing Institute

1450 Madruga Ave, #204, Miami, Florida, 33146
ph: 305.667.8174 fx:305.661.2327

Financial Responsibility

Patient Name: ______________________________ **Date:** ____________________

1- Please read and sign this form before seeing the doctor.

2- Full payment of the initial exam is due at the time of service.

3- You may use your medical insurance, but we will call the insurance company to verify your benefits. We will file insurance claims to your company however, if service is denied, is not a covered service, or if you are found to have a deductible or co-insurance amount, you will be responsible paying your co-payment or your balance at the time of your visit.

4- Sometimes the insurance will deny services. If this occurs, you as the patient are responsible for payment to the doctor. We are sensitive to this issue and we will try to warn you if we feel a service may not be covered. Ultimately the insurance contract is between you, your employer and your insurance company.

5- CASH patients are required to pay the full amount of the doctor visit.

Dr. Paul Canali does not mail invoices or statements to patients for balances. If we receive notice that there is a balance on your account, payment will be processed immediately. Please refer to your EOB from insurance company for balance. You will know if there is a balance on your account since you receive statements from your insurance company before we do. By allowing us to obtain a quick payment, we are better able to use our resources to provide medical care instead of using our staff time sending our statements and balance to collection agencies.

6- We will charge a fee of $30.00 per any return checks, for uncollected funds or NSF.

Cancellation Policy: You will be charged $50.00 if your do not cancel your appointment one (1) business day prior to scheduled appointment. Our business days are Monday, Wednesday, and Friday, excluding holidays. This charge must be paid in full before any newly scheduled appointment is made. Thank you.

______________________________ ____________________

Patient Signature Date

You will be asked to sign this form at the office.