Preferred Name (please print)

FEE AGREEMENT

Legal Name (please print) | Date of Birth | WellPower ID#

Welcome to WellPower! We are pleased to provide you with our services. Please review the following general terms and agreement of payment for services at WellPower:

GENERAL PAYMENT TERMS

- I understand that I am financially responsible for services, medications, or labs received at WellPower according to this Fee Agreement and the terms of my health benefits plan.
- I agree to pay my share of the cost, including copays, coinsurance, or deductibles for my services at the time of service as determined under my health benefits plan.
- In the event my benefit plan changes, I will inform WellPower staff.
- Should a financial hardship arise, that might prevent me from honoring this Fee Agreement, I agree to speak with WellPower ***before*** receiving further services to discuss my options regarding payment.
- I understand that if I receive any payment directly from Medicare, Medicaid, or my insurance carrier for services provided by WellPower, I must give the payment to WellPower. WellPower will refund to me or my insurance carrier any excess payment it receives, as appropriate.
- I authorize WellPower to bill my insurance carrier on my behalf and to receive direct payment for any insurance benefits payable for the services provided by WellPower.
- I authorize WellPower to release to my insurance carriers any information requested by the insurance company.

AGREEMENT. By signing below, I acknowledge that I have read and fully understand this Fee Agreement and that the information I have provided to WellPower is true and correct to the best of my knowledge.

X

Signature of individual or personal representative | Signature date

Name of personal representative (if applicable) | Relationship