BLUEZONEHEALTHNH.COM
P: 603-880-4150
F: 603-880-6765

29 RIVERSIDE STREET
UNITS A & B
NASHUA, NH 03062

MISSION: TO RAISE THE VIBRATION OF EVERYONE WHO WALKS THROUGH OUR DOOR.
VISION: TO REVOLUTIOIZE HEALTHCARE IN OUR COMMUNITY.

MAJOR MEDICAL INSURANCE POLICY AND INSTRUCTION OF PAYMENT

Our office is pleased to accept your insurance assignment as soon as your coverage has been verified. If you do not have a referral or your insurance is not assignable to this clinic, then you must pay in full at the time of service. The insurance company may reimburse you directly in these cases. Should your insurance require a referral/pre-authorization, this must be received in this office by your second visit. Initial insurance information must also be received in this office by the second visit. Otherwise your account may revert to a cash account until the information is received.

We provide direct billing and insurance verification of benefits as a courtesy to you, therefore we ask for your cooperation. You are ultimately responsible for knowing your benefits, and tracking your visits and the limitations imposed by the insurance company. Should your insurance coverage change it is your responsibility to inform us immediately. We are not obligated to back bill insurance and you are directly responsible for any balance due.

You must fully understand that your insurance contact is between you and your insurance carrier and that every individual policy varies regarding rules of specific coverage. Therefore, you are fully responsible for any amount not paid by your insurance company. This excludes specific HMO and PPO contracts in which we are participants. We will make every effort to see that your claims are paid. However, we will not enter into a dispute with your company over your claim. If we do not receive payment from your insurance company within 90 days it becomes your responsibility. All insurance companies state this disclaimer: **"Verification is not a guarantee of payment."**

I acknowledge and understand that the doctor may provide services that are not reimbursed by my insurance, and I understand that I am responsible for such charges. **(Initials here please): ___________**

Patient Name: ____

Claim or Group Number: ________________________________ ID Number: ____

Subscriber Name: _______________________________________ Subscriber DOB: ____

Subscriber Employer: ____

I hereby instruct and direct that ______________________________ company pay by check made out and mailed to:

Blue Zone Health, PC, 29 Riverside Street, Unit B, Nashua, NH 03062

If current policy prohibits direct payment to the clinic, then I hereby direct you to make the check payable to myself and Blue Zone Health and mail it to the above address.

This payment will not exceed my indebtedness to the above mentioned assignee, and I have agreed to pay, in a prompt manner, any balance of said professional service charges over and above this insurance payment.

I authorize the release or reception of any information pertinent to my case to/from any insurance company, the insurance adjuster, health care establishment, or attorney involved. I also authorize the doctor to complain on my behalf to the insurance commissioner if the insurance company defaults on this agreement for any reason.

I have read, understand and agree with the above policy.

Patient/Guardian Signature: ____ Date: _____________________________