

Mitchell Center for Natural Healing, PLLC
8814 Roosevelt Way NE
Seattle, WA 98115
206-284-6040

Financial Information

YOU ARE RESPONSIBLE FOR ALL YOUR MEDICAL COSTS. WE DO NOT ACCEPT OR BILL MEDICAL INSURANCE COMPANIES.

We will print you out an itemized invoice which you can submit to your insurance company for reimbursement to you if applicable. You are responsible for full payment of your bill at the time of service.

By signing below you agree to the following pertaining to personal financial responsibility:

- I agree to pay for all services at the time of service
- I agree to be responsible for all costs of collection, attorney's fees, court costs, or other entities deemed necessary for the collection of all unpaid balances. I also agree to the release of all pertinent information deemed necessary by such persons/agencies in the collection of all outstanding balances.
- I fully understand that the business of Mitchell Center for Natural Healing, PLLC does not accept or bill insurance for any services rendered.

By signing below, I agree that I have read the above information and agree to the terms put forth.

Signature: _____
(of patient or authorized representative)

Date: _____

Printed Name: _____
(of patient and authorized representative)

If signed by an authorized representative, please include your relationship to the patient:
_____ (parent, legal guardian, etc.)