

THE UNIVERSITY OF KANSAS PHYSICIANS

Program in Integrative Medicine

3901 Rainbow Blvd, Mailstop 1017

Kansas City, KS 66160

913-588-6208

Financial Agreement

Return Form to Patient Service Representative

I understand that payment is due at time of service. Acceptable forms of payment include cash, check, Visa, Mastercard, or Discover (no American Express). I understand that the Program in Integrative Medicine does not bill insurance for any clinic services, including consultations. If I have questions regarding my insurance coverage, I have been advised to contact my insurance company prior to scheduling any appointments. I have also been advised that reimbursement through my insurance company is highly unlikely because the ABC coding system used in this clinic and universally in Integrative Medicine is not reimbursed by most insurance companies.

I have read and agree to the financial terms above.

Patient Signature _____ Date _____

Witness Signature _____ Date _____

This one-year agreement expires on _____.
(date)