Divine Health Naturally LLC

9103 Marshall Road

Cranberry Township, PA 16066

724.355.9049

Financial Consent

I, the undersigned, understand that I am responsible and expected to pay at the time services are rendered and/or goods are received, unless prior financial arrangements have been made. I also understand that any services provided by Tracie L. O’Neil, will not be reimbursable by any insurance company, due to Tracie L. O’Neil’s non-licensable status in the state of Pennsylvania. Therefore, I also understand that Divine Health Naturally LLC will not process or assist in any claims, insurance or medical billing. I understand that it is my sole financial responsibility to Divine Health Naturally LLC for all charges incurred.

I also understand that Divine Health Naturally LLC, the office of Tracie L. O’Neil, has the right to access a cancellation charge to my billing information for missed appointments or appointments cancelled with less than a 24 hour notice.

Name (please print) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_