Herman Rus Medical Corporation dba Soft Reboot Wellness Payment Policy

I. Payment

By my signature below, I understand, acknowledge, and agree that I am fully responsible for payment of services provided to me by Herman Rus Medical Corporation dba Soft Reboot Wellness ("SRW") and that payment must be made in full by cash or credit card at or before the time of service.

I understand that treatment and services provided by SRW may not be covered by my insurance. SRW and its physicians are non-participating providers and do not contract with an insurance plan. SRW will provide information to me to assist me in my claim for reimbursement to my insurance carrier but will not submit claims to insurers on my behalf and is not required to speak with insurance companies on my behalf. SRW is also unable to fill out paperwork for insurance companies.

I understand I have the right to explore my options with Medicare, Medicaid, or other insurance companies whether outpatient or inpatient ketamine infusion is a covered benefit under my plan and to find another practice that may contract with Medicare, Medicaid, or other insurance companies.

I further acknowledge and agree that if I choose to submit any bill or itemized receipt to an insurance carrier for reimbursement for these services, SRW is exempt from any dispute regarding reimbursement.

Credit Card Information/Authorization

Card Type ☐ MasterCard ☐ DISCOVER NETWORK ☐ VISA ☐ FSA ☐ HSA ☐ venmo

Name on Card _____

Credit Card Number _____

Expiration Date _____ Security Code _____

Complete Mailing Address _____

City _____ State _____ ZIP _____

Authorization Signature _____

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II. Cancellation

To fairly and effectively serve patients who wish to receive treatment, the following cancellation policy has been implemented. By your signature below you acknowledge and agree to the following cancellation policy: All appointments must be cancelled at least 48 hours before your scheduled Treatment. Otherwise, you will be charged for a missed Treatment. SRW will keep your credit card on file and charge you for any missed or late canceled appointments.

I understand and agree that my credit card information will be kept secure and used only as described in sections I and II above.

Patient Name _____ Date _____

Patient/Patient Representative Signature _____