Theresa Martez, ND, LMP
Stacy Bowker, ND
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Cedar Avenue
INTEGRATIVE MEDICINE

Cassandra Hurd,ND,LM
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Acknowledgement of Receipt:

Financial Policy

The following outlines our financial policy. Please review carefully and sign/date it.

- Payment is due at time of service. The provider may arrange this differently under certain circumstances. Acceptable forms of payment include cash, check, Visa, & MasterCard. Insurance is also accepted.
- Patients who pay out of pocket for their visit will ONLY be given a 25% discount if they pay at time of service.
- Nutritional supplements must be paid for at the time of purchase, regardless of insurance.
- Please give us 24 hours' notice if you can't make your appointment. Failure to give 24 hours advance notice for appointment cancellations may result in a fee. Patients will now be billed **$45.00 for appointments that are cancelled with less than 24 hours' notice**. Special circumstances may waive this fee. The front desk will now remind patients of this policy when they call for appointment reminder.
- Some services, including phone and email consultations, may not be covered by health insurance. Patients will be billed **$25.00 for emails requiring more than a 2 sentence answer**. Please give us at least 24 hours to respond appropriately. Patients will be billed **$25.00/15 minutes for a phone consult** or phone conversation that can't be made into an office visit.
- Patients may be responsible for charges incurred by using the practitioner's pager, cell phone, or text service outside of normal business hours (Monday-Friday: 9am-6pm). This fee will be $30 per page, cell phone call, or text. We encourage all patients to call the front desk with immediate concerns during normal business hours.
- Patients are responsible for all bank charges and fees resulting from a returned check.
- Accounts more than 60 days overdue will incur financing charges of 1% per month on any outstanding balance.

Insurance: Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We will bill your insurance as a courtesy for which we are contracted providers, as long as you provide us with your current and correct information.

I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any balance. I also authorize my provider or my insurance company to release any information required to process my claims. I understand that payment is dependent on my eligibility at the time of service and ALL terms and conditions of my insurance plan. I also acknowledge that certain services may not be covered by my benefit plan, or deemed medically unnecessary, and agree to pay for any Non-Covered Service, such as phone or email consultations and outside labs. This authorization shall remain valid until revoked by me in writing.

Payment Issues: If financial problems arise, please contact our office ASAP. Installment or payment arrangements can be implemented. Balance will become due immediately if you break rules of the plan.

I have carefully read the Financial Policy. I understand and agree to the terms therein.

_____ _____
Signature of Patient or Responsible Party Date

_____ _____
Print Patient Name Date of Birth