Natural Wellness Centre

Dr. James Grilliot
Chiropractic Physician

NUTRITION FINANCIAL POLICY

Thank you for choosing us as part of your health care team. We are committed to your treatment being successful. The following is a statement of our Financial Policy, which we require you to read and sign prior to any treatment. The purpose of our financial policy is to keep *health care costs down.* All patients must complete and sign our entrance forms and financial policy before seeing the doctor.

Nutrition Patients
Payment in full is due at the time of service. Please note, all services are to be paid in full at the time of your visit. All sales are final. We accept cash, checks, Visa/MasterCard, American Express or Discover. We do not allow any returns on all supplements as we are unable to control the temperature of these products once they leave the office.

Regarding Insurance
We will not accept assignment of insurance benefits for nutritional based services. We will provide you with appropriate codes on any testing procedures ordered so you may submit them to your insurance carrier if you so choose. Hair analysis testing is paid to our facility. All other testing: blood, saliva and/or stool is paid directly to the lab by the patient.

Usual and Customary Fees
Our practice is committed to providing the best treatment for our patients and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Missed Appointments
Nutrition/alternative medicine appointments must be canceled at least 24 hours in advance to avoid being charged forty-five dollars ($45.00) for your missed appointment time-slot. Please help us serve you better by keeping your scheduled appointments.

Cancellation
If you terminate all future appointments, under any of our Value Plans (#1,#2,#3), any payments made on your plan for office visits, nutritional supplies, various examinations and tests will be assessed as a Pay As You Go, (itemized service) under the option #4 plan. A $50 re-processing fee will also be assessed. **Initials:**_____

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I understand and agree that health and accident insurance policies are an agreement between my insurance company and myself, not between my insurance company and this office.

I authorize Natural Wellness Center to release any medical information necessary to assist in collecting from my insurance company if I so choose.

I have read, understand and agree with this financial policy.

_____ _____
Signature of Patient or Responsible Party **Date**

_____ _____
Signature of Insurance Department **Date**

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