Payment Agreement & Cancellation Policy

Please read the following agreement. It explains your financial obligations while under our care and our policies regarding cancellations.

- Payment is always due at the time of service.

- We accept the following forms of payment:
  - Cash
  - Check
  - Debit Card
  - Visa
  - Master Card

- We do not accept insurance, however:
  - If you have a PPO-style plan (these are plans that allow you to see doctors who are not part of your insurance company's provider network), we can do the following:
    - Prepare a health insurance claim form that you can submit to your insurance company to request reimbursement of your visit charges.
    - Bill your insurance company for labs and imaging studies.
    - We can never guarantee that your insurance company will reimburse you for your visits or cover the cost of your labs and imaging studies. You are ultimately responsible for the cost of your care at our office.

- All new patients are required to provide a valid credit card number, including expiration date and billing zip code, in order to schedule a new patient appointment.
  - New Patient Appointments:
    - If you cancel your appointment with less than 48 hours' notice, or fail to show for your appointment without notification, your credit card will be charged $100.
    - If you call to cancel your appointment with less than 48 hours' notice and choose to reschedule another appointment at that time, your credit card will be charged $50.
    - If you reschedule your appointment and then cancel with less than 48 hours' notice, or fail to show for your appointment without notification, your credit card will be charged for the full price of the visit.
  - Follow-Up Visits:
    - If you cancel a follow-up visit the day of your scheduled appointment, or fail to show for your appointment without notification, your credit card will be charged $25.

- Regretfully, we have been forced to institute this policy due to a large volume of last-minute cancellations, scheduling changes, and “no-shows.”
- We have a very busy practice. Assuring that all our established patients have access to their doctor when necessary is a constant challenge. When you cancel or reschedule with adequate advance notice, it is more likely that another patient in need will be able to use your time-slot. When you cancel or reschedule at the last minute, or fail to show for your appointment, you are depriving another patient the care they need.
- New patient visits require our doctors to block out large time slots, making last-minute cancellations and rescheduling of visits even more problematic. We spend an inordinate amount of time and energy with each and every one of our new patients because we are committed to providing the highest quality care to be found anywhere. Again, please be aware that when you cancel or reschedule at the last-minute you are depriving care to another patient in need.

- Phone Consultations:
  - We bill for phone consultations. They require the same time and expertise as office visits.
  - Billing for phone consultations is, however, at the doctor’s discretion. Your doctor may choose not to bill you if the nature of the phone consultation is uncomplicated, such as taking a minute to answer a question about your treatment protocol. If any type of extended discussion ensues or if a number of questions need to be addressed, it is likely your doctor will bill for the phone consultation.

By signing this payment agreement & cancellation policy, you are indicating that you understand and agree to the terms of service explained above. You are also indicating that you have given your permission to us to charge your credit card if any of the above stipulations apply to you.

Name of Patient or Legal Guardian:_____

Signature:_____ Date:_____

Type of Card: Visa MC Card Number:_____

Expiration:_____ Security Code:_____ Billing Zip Code:_____

Confidentiality Statement

Your privacy is important to us. All medical records and interactions between doctor and patient are entirely confidential.

Outlined below is a brief summary of your rights and protections under the Health Insurance Portability and Accountability Act (HIPAA). You can learn more about your rights from the website at http://www.hhs.gov/ocr/hipaa/ or by calling 1-866-627-7748.

You have the right to:

- Ask to see and get a copy of your health records.
- Have corrections added to your health information.
- Receive a notice that tells you how your health information may be used or shared.
- Decide if you want to give your permission before your health information can be used or shared for certain purposes, such as marketing.
- Request where you would like to be contacted.
- Ask that your information not be shared. For example, you could ask your doctor not to share your medical record with other doctors in the office.

If you believe your rights are being denied or your health information isn't being protected, you can:

- File a complaint with your doctor.
- File a complaint with the U.S. Government.

If it is necessary to reduce or prevent a serious threat to your health and safety, or the health and safety of another individual or the public, your doctor has the obligation to disclose any relevant information.

Name of Patient or Legal Guardian:_____

Signature:_____ Date:_____

Naturopathic Health Associates LLC

Dr. Eric Udell ND
Dr. Danite Haller ND
Dr. Laurinda Kwan ND
Dr. Tara Peyman ND
Dr. Natalie Ham ND

Advanced Beneficiary Notice (ABN)

Medicare/Insurance Company Does Not Pay For All Health Care Costs.

The fact that Medicare/Insurance Company may not pay for a particular service or test does not mean you should not receive it. Your doctor may have good reason to recommend you have this laboratory test(s). The purpose of this form is to help you make an informed choice, on whether or not you want to receive these tests or services, knowing that you might have to pay for them out-of-pocket.

Your doctor will be glad to explain the test to you and why it is necessary. The Laboratory Tech will give you the estimated cost.

Please choose one option below:

☐ Yes. I want to receive these laboratory tests.
I understand that Medicare/Insurance Company may not pay for these tests and I will be responsible for these charges.

☐ No. I have decided not receive these laboratory tests.
I understand that by not having these tests done, my doctor may not be able to give a complete and informed treatment plan for my condition.

Ordering Physician:_____

Patient Name: _____

_____ _____
Patient/Responsible Party Signature Date

_____ _____

Witness Signature Date