



FINANACIAL RESPONSIBILITY AND POLICY STATEMENT

Thank you for choosing True Vitality Naturopathic Medical Care (TVNMC) for your healthcare needs. Our healthcare providers and staff are committed to enhancing the quality of your care and overall health. This policy statement is designed to inform you of our policies and answer questions regarding payment for services.

PAYMENT FOR SERVICES

TVNMC is a fee for service clinic. Patients are to assume all financial responsibility for the office visit and services rendered during the time of service.

For your convenience, we accept cash, personal checks, Visa, MasterCard, Discover and American Express. Returned checks are subject to a \$30 return fee and no further personal checks will be accepted.

TVNMC does not currently bill insurance, however we will provide you with the necessary materials so that you may do so. We are currently not covered by Medicare and therefore are unable to submit such claims.

PHONE SUPPORT

Phone support is to aid in answering any questions or concerns that may arise, or to clarify instructions. This is not intended to take the place of an office visit.

Phone consultations that cover new material, require new information, take an extensive amount of time, or require a change in the treatment plan are considered substitutes for an office visit. These will be billed for the same rate as the visit for which they substitute. For example, a phone consultation that substitutes for a limited visit will be billed as a limited visit.

CANCELLATION POLICY

TVNMC has a 24-hour cancellation/reschedule policy. If you do not call the medical clinic at least 24 hours prior to your scheduled appointment, you will be charged a \$30 fee for the appointment. There is no charge if an appointment is cancelled or rescheduled more than 24 in advance of appointment.

I have read, understand and accept the information and conditions specified in this document. In case of default of payment, I am responsible for full payment of the balance, interest accrued, and any collection costs and legal fees incurred to collect on this account.

Patient Name: _____ Date: _____

Patient / Guardian Signature: _____