



## NEW PATIENT OFFICE POLICY

**Please read and understand the following:**

We are in-network and can accept the following insurance plans: Aetna, Anthem Blue Cross Blue Shield, Cigna, Connecticare, Healthy CT, and PCHS. However, in the event your health plan does not cover the services provided, you are responsible for any incurred charges.

Clinic policy requires that copayment and coinsurance are paid at the time of the visit. If you have an unmet deductible, including Health Savings Account compatible plan, full payment of the contracted rate for your visit is required at the time of the visit.

Full payment is expected at the time of the visit if you have any insurance not listed above including: Medicare, Medicaid, Oxford, United Health, Tufts, Heath New England, and Tricare.

If you have no insurance, full payment is expected at the time of the visit.

**Out of network lab testing, lab service fees (incurred in our office), and supplements are not billable to insurance and may be charged separately.**

Lab testing through reference laboratories is usually covered by insurance. It is your responsibility to determine your insurance coverage for lab testing. The cost of an office visit does not include pharmacy items and/ or laboratory testing.

Phone consultations can be arranged for patients under special circumstances. There is no fee for calling to clarify treatment plan instructions. Phone calls will be returned within 48 hours. **In case of emergency please call 911, or go to the nearest emergency room.**

To avoid a \$75.00 charge for a missed appointment, you must cancel or reschedule your appointment 24 hours in advance. In addition, should an unpaid balance require multiple billing statements, to the extent allowed by law, you may be charged a \$45.00 administrative fee.

By signing below, I agree that I have read and understood this policy. I guarantee payment of all charges incurred as a patient of Nature's Helper Medical Clinic.

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

Printed Name: \_\_\_\_\_

Parent or Guardian (minor): \_\_\_\_\_

Date: \_\_\_\_\_