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FINANCIAL POLICY STATEMENT

Dear New Patient,

Welcome to **Foundations Family Wellness**. We look forward to providing for your health care needs. We encourage your questions and participation in all aspects of your care. **Please read and initial the following statements:**

_____ Payment for all services and medicinary items is due at the time of the visit. We accept cash, checks, Visa, MasterCard, Discover, and American Express. Returned checks will be subject to a $35.00 NSF fee.

_____ Insurance billing is not provided at this time by Foundations Family Wellness. An insurance super-bill will be provided at the time of service for submission to your insurance company. At this time, most insurance companies in California do not provide Naturopathic coverage; however, certain services and diagnoses may be covered.

_____ Phone calls and emails regarding an existing health issue that require more than 10 minutes of attention from your physician will incur a fee. Phone calls and emails regarding a new health issue, regardless of the length of time of attention required, will also incur a fee. Your physician will notify you of the need for a charge, so that you can determine whether you would like to address the issue and pay the fee, or schedule an appointment. Phone and email charges are not billable to insurance.

_____ You will be charged a Missed Appointment Fee of $50.00 for any missed appointments or late cancellations (less then 24 hours notice).

_____ Your health care provider may prescribe medication, which may be purchased at Foundations Family Wellness Center or elsewhere. Most insurance companies do not cover the pharmacy items that we prescribe and dispense.

I have read and understand the above-stated policies of Foundations Family Wellness Center and will comply with them in all respects. *If my insurance company requires release of my medical records, I hereby give my permission by signing this form.*

_____

Patient Name (Please Print. Include parent/guardian name if patient is a minor.)

_____ _____/_____/_____

Patient Signature (Parent/guardian signature if minor) **Date**