Natural Rhythms
AYURVEDIC NATUROPATHY

Payment Agreement Form:

Fees:
Introductory or Problem-focused visit: 30mins -- $125 (variable) for insurance clients; $100-125 out-of-pocket.
Naturopathic First office visit: 1.5hour -- $205 (variable) for insurance patient; $180 out-of-pocket.
Naturopathic Follow-up visit: 45 mins -- $175 (variable) for insurance patients; $145 out-of-pocket.
Procedural visit: 1 hour – $90 out-of-pocket; Plus: cost of materials (variable)
** Extended visit charge for follow-up visits that are over 75mins billed to insurance (Variable). Out of pocket charge: $45.

Payment

Payments for office visits, supplements, and all procedures is due at time of service. We accept cash, checks, Visa, and Mastercard. We can accept payment from your HSA. Payment plans can be made available individual basis, on request. The fee for returned checks or notice of insufficient funds is $35.

Insurance

Currently, Dr. Anup Mulakaluri is in-network with Regence, BlueShield, Premera, BlueCross, First Choice and Lifewise.

All payments are due at the time of service, without exception. If your insurance allows Naturopathic Care, we will submit reimbursement paperwork to your insurance company, as a courtesy to you. If you do not know if naturopathic medicine is covered, you can call your insurer to find out. Insurance may not cover all fees, such as vitamin injections or outside labs that are considered investigative. We will do our best to make you aware of these non-covered fees ahead of time, so that you can choose if you'd like to go forward.

Payment Plan:

In case of economic hardship or with intention mitigate financial burden, we offer financing for up $775. You will be require to repay this at a monthly payment rate of $45-75, scaled depending on amount owed by you. An interest of 3% will be added to your credit to moderate the cost of transactions. If you would like to participate in a payment plan, initial here ___, then complete Credit Card approval.

Cancellation Charge

We require 24 hours notice for canceled or rescheduled visits. There is no charge for visits canceled with 24 hours notice. Half the cost of the scheduled visit will be charged for cancellations with less than 24 hours notice. Full fee is charged if no notice is received.

Lab Work

Lab work originating from our office may be covered by your insurance company. The laboratory handles all billing and will bill you or your insurance company directly.

Return Policy

All dispensary items must be paid for at the time of purchase. Credit on your account will be given for unopened items in perfect condition if returned within 30 days. No credit will be given for items returned after 30 days. Refunds cannot be made.

Print Name_____ **Sign:**_____ **Date:**_____

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FORMS OF PAYMENT – In addition to cash or check, we kindly accept Visa, MasterCard, and Discovery for payment of services. There will be a $35.00 fee for checks returned for insufficient funds.

COLLECTION NOTICE – I understand that any and all accounts that become 90 days delinquent are subject to collections and may incur a $25.00 collection fee.

Insurance Company:_____ **ID#:**_____

Subscriber Name:_____ **Group#:**_____

_____**I certify that I am eligible for benefits under my prepaid health benefit plan. In the event that I am later found to be ineligible or in consideration of being treated without proof of eligibility, I agree to pay for any and all services provided by my individual practitioner based upon regular fees then in effect.**

_____**I understand that all Co-pays will be due at the time of service and that all non-covered, co-insurance, and Deductible amounts must be paid within 30 days of receipt of notice from my insurance or Nightingale Medical Billing.**

_____**I grant permission to Nightingale Medical Billing to submit claims on my behalf to my insurance carrier for services provided by Dr. Anup Mulakaluri.**

_____**I authorize the release of any medical or other information necessary to process my claims.**

_____**I authorize payment of medical benefits to "Natural Rhythms Integrative Medicine" directly from my insurance carrier.**

I have read and understood the above information and have been provided with a copy at my request.

_____ _____

Patient Signature or Parent/Guardian (if under 18 years of age) **DATE**

_____ _____

Patient Name **Patient D.O.B.**