

PATIENT INFORMATION

Name _____ Age _____ DOB _____ M / F

Home Address _____

City _____ State _____ Zip _____

Home Phone () _____ Cell Phone () _____

Email _____ Occupation _____

Employer _____ Work phone () _____

City _____ State _____ Zip _____

Parent or Guardian (if under 18) _____

PAYMENT POLICY All charges are due in full at the time of visit, unless insurance is billed (see below). We except local check or cash, Visa / MC, or Discover. We do not establish accounts or bill monthly. Initial _____

FEES: Our office/outpatient visit charges reflect average insurance billing / reimbursement rates. E.g. 1 hour first visit (CPT-99205) \$215.00; 45 minute first visit (CPT-99204) \$165.00; 25 minute established visit (CPT-99214) \$95.00; 15 minute established visit (CPT-99213) \$65.00. Laboratory fees, procedures, and prescribed dispensary items are additional cost. Certain therapies have a separate fee structure. For all other fee information, please inquire prior to your visit.

INSURANCE BILLING: At this time we accept Regence / BlueShield. Co-pays and deductibles are collected at the visit. You must present your insurance card when arriving otherwise you will be rescheduled. Portions listed as the patient's responsibility on insurance payments is due in full by you at that time. We do not bill for monthly payments, Medicare or Medicaid. An itemized receipt showing all charges will be given at the completion of each visit.

Other Insurance: Many companies do offer coverage for naturopathic medicine. We recommend that you contact your insurance carrier and inquire about this prior to scheduling. If you request, an insurance superbill will be provided for you to submit.

Non-covered services: Your insurance policy may not cover all procedures, laboratory tests and other services performed here. We fully disclose non-covered services and these charges will be your responsibility following your prior signed consent to perform them. Nutritional supplements, vitamins, natural medicines, compounded prescriptions, and prescription medication that are dispensed and purchased through the clinic are not covered by insurance. Initial _____

Regence / BlueShield Insurance Information

Regence Plan: _____ Toll free # _____

Submittal Address _____

I.D. # _____ Group # _____

Policy Holder _____ Relationship _____

CANCELLATIONS: We request at least 48 hours notification if you must cancel your visit. If you fail to notify us of your cancellation within 24 hours of your visit, you will be charged \$65.00.

ASSIGEMENT AND RELEASE: I authorize payment of medical benefits directly to the undersigned physician from my insurance company. I am financially responsible for all non-covered services as outlined above, including cancellation, collection and interest fees. _____ Initial _____

Signed _____ Date _____

How did you hear about us? Friend / relative _____ Practitioner _____ Ad _____ Talks _____ Phonebook _____ Other _____

Name of person or doctor who referred you: _____ (optional)

Policy and fees subject to change without notice. © The Good Doctor, Inc. 2004