Craig Peterson, ND, LAc, FABNO

INTEGRATIVE ONCOLOGY

PATIENT FINANCIAL AGREEMENT

By signing this Patient Financial Agreement, you acknowledge that you have read and understood the financial policies of Dr. Craig Peterson and agree to be bound the terms of the agreement.

Naturopathic & Acupuncture Office Visits: (variable depending on time and complexity)

- First office visits are an extended visit, allow approximately 1 hour.
- Return office visits may or may not be considered extended depending on time and complexity of visit, please allow 30 minutes for this visit.
- For an estimate on pricing please contact the office.

Phone consultation:

- These fees are applied when consultations are conducted over the phone instead of an office visit.
- The cost varies dependent on time spent and complexity and while they are billed same as an in-office visit.
- If there are any questions about this service, please ask at the time of the call.
- Please be aware that insurance does not cover phone consultation.

Email:

- **PLEASE NOTE**: Healthcare services will not be provided via email. Emails will only be used for scheduling appointments or confirmation of a previously recommended treatment. All other email requests will be directed to an office visit or phone consultation.

Cancellation Charge:

- There is a $50 fee with less than 24-hour notice or for a NO-Show.

Payment:

- Payment for visit co-pay and/or medications and supplies to be billed for patients. Non-covered insurance or cash patients are welcome to pay at time of service with cash, check or credit/debit card. A 15% Time of Service Discount may be applied.
- There is a minimum billing fee of 12%, applied to account balances due beyond 30 days.
- There is a $35 NSF fee on all returned checks.
- Patients will be held responsible for non-payment by their insurance company. Accounts unpaid by the insurance company greater than 90 days will be billed to the patient.
- Outstanding balances greater than 120 days will be turned over to a collection agency unless prior arrangements have been made in writing.

IF I HAVE INSURANCE, I UNDERSTAND THAT I AM RESPONSIBLE TO READ MY MEDICAL BENEFIT BOOK AND UNDERSTAND IT. I AGREE THAT I AM FULLY RESPONSIBLE FOR THE TOTAL PAYMENT OF ALL PROCEDURES PERFORMED IN THIS OFFICE. THIS INCLUDES ANY TREATMENT THAT IS NOT A BENEFIT OF ANY MEDICAL INSURANCE THAT I MAY HAVE.

I, _____ , agree to the above financial policies of Dr. Craig Peterson, Puget Sound Integrative Oncology PLLC. In the 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. I have filled out and understand the scope and limitations of my insurance coverage and agree to pay all fees not covered by my insurance plan (see attached Patient Responsibility & Insurance Benefit Disclosure form). I, the undersigned, have read, understand, and accept the information and conditions specified in this document.

_____

Print Name

_____ _____

Client Signature Date