NATURA MEDICA
12 Roosevelt Ave Mystic CT 06355
860-572-9566

Financial Policy (page 2)

PATIENT NAME:___________________________________

DOB: _____________________

If you wish to keep your credit card on file, please fill out below. Please note that your card will be charged for the amount due per your insurance company, this may be in addition to a copay which is due at the time of visit. If your cc is on file and you wish to use that for pharmacy, it may take 24-48hrs for your order to be filled.

I hereby authorize Integrative Wellness Center, LLC dba Natura Medica to charge the payment:

Name on card: ________________________________

Account # ____________________________________

3 digit code: _________ Expiration Date: _____________ Zip code: __________

______________________________________ (Patient/ Guarantor Initials) SIGNATURE

If you do NOT wish to keep your credit card on file:

A) You have a HIGH DEDUCTIBLE (which will be determined after the initial EOB is received)
Then you will pay a PREPAYMENT FEE (a set amount) at the time of visit.
Please note this is IN ADDITION to you COPAY.
You will be mailed a statement for the difference owed.

B) You are SELF PAY. Payment is due in full at the time of service.

Any questions or concerns that I may have had concerning this agreement were answered or discussed by a staff member of Natura Medica. IF this agreement needs to be altered at any time, I will contact the office, 860-572-9566, to discuss further options.

Patient/ Guarantor Initials ______________

Patient or Guarantor Printed name ___________________________________

Patient or Guarantor signature ____________________________________DATE:____________

Signature of this document denotes all parties agreed to the terms listed above

We value the healthcare relationship we have built with you and appreciate your diligence to fulfill your patient responsibility ***Natura Medica***

☐ Patient requests copy ☐Patient deferred copy