Patient Payment Plan

Patient Name: _____

Responsible party: _____

Patient address: _____

Patient phone number: _____

I, _____, understand that I am agreeing to the following payment plan between myself and Integrative Wellness Center, LLC dba Natura Medica. I understand that should I at any time deviate from the prescribed payment plan (including but not limited to: missed payments, declined payments or payments not made in full) Natura Medica reserves the right to charge interest, penalties and /or consider my payments delinquent and send me to a third party collection agency.

1) My current patient account balance is $_____as of _____(date)

Insurance claims pending: YES NO

I further understand that if insurance claims are pending, that I may owe an amount in addition to the amount listed above; and agree to pay that amount based on this payment fee schedule.

Patient/ Guarantor Initials _____

2) Initial payment of $_____ paid on _____.
3) The monthly payment will be $ _____ and payment will be due on the first (1st) of each month until patient balance is $0.00.
4) I will be paying by check (Natura Medica), due on the 1st of the month _____(initials)
5) I hereby authorize Integrative Wellness Center, LLC dba Natura Medica to charge the aforementioned payment on the first/ 1st (or 1st business day) of the month (from my credit/debit account until paid off:

   Account # _____

   3 digit code: _____ Expiration Date: _____ Zip code: _____

6) 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***