Patient Name_____ **Date of Birth**_____

Natura Medica

12 Roosevelt Avenue Mystic CT 06355 Tel 860 572-9566 Fax 860 572-7318 www.naturamedicamystic.com

Financial Policy Page 2

1) **Deductible Prepayment** - If you have a high deductible, **OR** we have received your Explanation of Benefits showing deductibles due, you will be charged a set amount at the time of visit to go toward your expected deductible balance.

   The amount due at the time of visit will be based on the complexity of the visit and will range from $40 to $100, ***IN ADDITION TO YOUR COPAY***.

   *****You will be sent a statement for the difference owed.***

   I CHOOSE THIS OPTION _____ (Patient/ Guarantor Initials)

2) **Credit card on file** - In the event an Explanation of Benefits is returned to us with an outstanding balance due to Copay or Deductible your card on file will be charged and an email receipt will be sent.

   I CHOOSE THIS OPTION _____ (Patient/ Guarantor Initials)

   I hereby authorize Integrative Wellness Center, LLC dba Natura Medica to charge payments due to:

   Name on card: _____

   Account # _____

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

   Email address for receipts _____

3) **I DO NOT have insurance or have insurance that DOES NOT COVER NATUROPATHIC CARE**

   I CHOOSE THIS OPTION _____ (Patient/ Guarantor Initials)

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 _____

Guarantor Printed name _____

Patient or Guarantor signature _____DATE:_____

Signing 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