Financial Policy Payment Choices

1) **Prepayment** –a set amount toward deductible charged at the time of visit, in addition to copay

	Billing code	Pre-Payment Amount In Network Insurances	ConnectiCare
a.	99213:	50.00	40.00
b.	99214:	75.00	60.00
c.	99215:	100.00	85.00

You will be sent a statement for the difference owed.

I CHOOSE THIS OPTION _____ (Patient/ Guarantor Initials)

2) **Credit card on file** for payment of amount due, in addition to copay
   a. As a courtesy we will send an initial invoice/ statement for the allowable charge (the allowable charge is the amount the insurance company "allows")
   b. After 45days if no payment has been received, your credit card on file will be charged the amount due per the insurances allowable charge.
   c. The 45days allows you the opportunity to pay your balance via a check/ or make a payment plan (forms on our website) with our office

   I CHOOSE THIS OPTION _____ (Patient/ Guarantor Initials)

   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: _____

3) I do not have a deductible – or - I am a Self-Pay patient and understand that Self-Pay discounts only apply for visits paid in full at the time of service. _____ (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 _____

Patient Printed name _____

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