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# Financial Policies and Fees

Thank you for choosing Dr. Chad Aschtgen as your naturopathic physician. Please read the following financial and fee policies thoroughly prior to your first visit. It is important that you understand our billing and fee policies. If you have any questions or need clarification, please feel free to ask.

## 1. Payment policy

**All fees are due at the time of service.** If however, you are covered by a health insurance plan that we are presently contracted with and you have naturopathic care benefits, we will bill your insurance carrier directly. **Please note that if you are responsible for a co-payment, this will be due at the time of service and payable by cash or check only.** If you do not have health insurance or have a plan that has not contracted with Dr. Aschtgen, a 20% prompt payment discount is available on office charges when payment is received at the time of service; again by cash or check only (credit and debit cards are not presently accepted).

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*initials*

## 2. Insurance

Please remember that while naturopathic medical services are covered by many insurance carriers, each company, their various plans and individual policy benefits can vary greatly. Although our staff will assist you as a courtesy, it is ultimately your responsibility to be aware of the benefits, limitations, payment requirements and specific exclusions of your health insurance coverage. For each covered service and/or procedure provided, we will only charge your insurance the "allowable amount", as defined uniquely by each individual carrier, and will not bill you for the difference (excluding co-payments, applicable co-insurance and any deductible amount as defined by your individual health plan).

Some of the testing, procedures and therapeutic products recommended by Dr. Aschtgen may not be covered by your insurance plan. Additionally, your insurance company may refuse coverage or pay only a portion or percentage of fees. **You will be responsible for any and all allowable fees not covered by your insurance plan.**

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## 3. Non-covered services

Non-covered services are those visits, procedures, diagnostic codes, telephone consults, *et cetera*, that are not covered by your health insurance policy. **We will bill you directly for any denied charges or non-covered services.** These may include, but are not exclusive to, the following:

- Naturopathic care services
- Wellness visits and non-curative/palliative treatments
- Counseling
- Functional lab tests; often considered 'investigational' or 'experimental'
- Missed appointments

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## 4. Appointment Change, Cancellation and No-Show Policy

We require at least one day (24 hour) notice for changing or cancellation of any appointment. **A 'no-show' or cancellation without a minimum 24 hour notice may result in a $50 cancellation fee.** Exceptions include medical emergency, severe/inclement weather, or other situation deemed acceptable by the individual practitioner.

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*initials*

**5. Fees**

- *Emergency Telephone Consults/Pager Fee* - $25.
  Although I do not function as your primary care physician, I am available 24 hours/day for urgent health concerns that cannot wait until a regularly scheduled appointment. A simple question that can be addressed briefly, such as dose clarification or identifying a high quality supplement brand, will not generate a fee.
- *Home Visits/House Calls* - $175.
  Unfortunately the majority of health insurance policies do not cover these visits.
- *Missed Appointment, Late Change or Cancellation Fee* - $50.
- *Nutritional Supplements*
  Dietary supplements recommended by Dr. Aschtgen are typically not covered by health insurance; although you may be eligible to apply funds from your *Health Savings Account* (HSA). You may purchase high quality vitamin, mineral, protein and herbal supplements from numerous sources and we will provide multiple recommendations for in-store, on-line or local physician office resources as a convenience.
- *Medical Records Requests* – 1st Free/$15.00 per visit note thereafter.
  As a courtesy, we will provide you with a free first copy of your medical record/chart notes upon request. Subsequent requests will generate a fee of $15.00/visit note plus any administrative costs incurred (e.g. copies, postage, etc.). Upon request and with a qualifying release, records are provided to coordinating physicians and other qualifying health care practitioners free of charge.
- *Email Policy*
  To provide you the best care possible, **we will not provide healthcare services via email correspondence**. If desired however, you can request to receive administrative and certain follow up information via email.
- *Delinquent Account* - $20 service charge, plus 1.5% monthly penalty of the remaining total balance
  Outstanding, unpaid accounts may be charged a service fee of $20 at 180 days from date of initial charges to cover cost of repeated invoicing. This fee may reoccur every 180 days thereafter. Further, a 1.5% monthly penalty fee may be applied to all outstanding balances older than 90 days. Any charges pending payment from third party payers will be exempt from such fees.

**I understand that it is my responsibility to know and understand my health insurance policy and its benefits. I acknowledge that I have read, fully understand and agree to these financial terms and fee policies.**

| ______________________________ | ______________________________ | |
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| *Print Patient's Name* | *Patient's Signature* | *Date* |
| *Print Name of Guardian or Responsible Party* | *Signature of Guardian/Responsible Party* | *Date* |

## Assignment of Benefits

**I, ______________________________, hereby assign the medical and/or surgical benefits that I am entitled to, and may otherwise be payable to me, under my health insurance plan to Chad D. Aschtgen, ND, FABNO. Further, I authorize Dr. Aschtgen and/or his office staff to furnish my health insurance company all medical and administrative information that may be requested in order for payment of benefits. This signed authorization is intended to apply to all insurance submissions whether manual or electronic. Finally, I accept full responsibility for all charges not covered by my insurance plan, including those that may be deemed 'not medically necessary'.**

| ______________________________ | ______________________________ | |
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| *Print Patient's Name* | *Patient's Signature* | *Date* |
| *Print Name of Guardian or Responsible Party* | *Signature of Guardian/Responsible Party* | *Date* |