



Payment Agreement

Welcome to my clinic. I look forward to providing for your health care needs. I encourage your questions and participation in all aspects of your care, and therefore want to inform you at the outset of our relationship of my financial policies. I thank you in advance for reading the following statements. Please sign at the bottom of this page signifying your understanding of them.

Appointment cancellation: 24 hours' notice is required for cancellation of appointments. Missed Appointment Fees of \$100.00 for a missed initial appointment and \$60.00 for a first missed follow up appointment will apply in the absence of 24 hours' notice of cancellation. Thereafter, full appointment fees are due for any missed appointment.

Insurance coverage of consult fees: Dr. Leah Olsen, ND is not currently a provider with any insurance plan. If your plan has coverage for out-of-network naturopathic care, Dr. Olsen will provide you a receipt for services with which you can claim direct reimbursement from your insurance company.

Insurance coverage for supplements: Dr. Olsen may prescribe nutritional, herbal or homeopathic supplements which may be purchased at this clinic or elsewhere. Most insurance companies do not cover supplements that Dr. Olsen prescribes.

Payment due at time of service: Payment for all services and medicinal items is due at the time of the visit. I accept cash and checks. Returned checks will be subject to a \$40.00 NSF fee.

Refunds/returns: Consultation fees are not refundable. Unopened medicinal items purchased at Dr. Olsen's clinic are returnable within 14 days of purchase, for credit only. Refrigerated items and custom-blended tinctures are not returnable. In the event that I open and begin to take a nutritional, herbal or homeopathic supplement prescribed by Dr. Olsen and have concerns about my response to that supplement, I agree to inform Dr. Olsen within not more than 48 hours so that she can adjust my treatment instructions as necessary. I understand that in the absence of such 48-hour notification, opened supplements are not returnable.

I have read and understand the above stated policies and agree to comply with them in all respects. If my insurance company requires release of my medical records, I hereby give Dr. Leah Olsen my permission to release my records by signing this form below.

Patient Name (Please Print. Include parent/guardian name if patient is a minor)

Patient Signature (Parent/guardian signature if patient is a minor) Date