BEARCREEK
NATUROPATHIC CLINIC LLC

1603 E BARNETT RD, MEDFORD, OR 97504
PH 541.770.5563 • FX 541.772.3028
WWW.BEARCREEKCLINIC.COM

PAYMENT POLICY

Delayed payment of office visits generates problems, as we are required to pay our bills and wages promptly. Therefore, in order to keep our services available to you, it is important that you understand and comply with the underlying terms of this payment policy.

1. Patients are always *responsible for full payment of their bills regardless* of insurance coverage, accident cases or other legal involvement. *Please note, this means that you will be expected to pay any costs denied by your insurance company.* Initially, we will bill you for these uncovered expenses, but, as we become acquainted with the terms of your insurance plan, we will make an effort to incorporate this cost into your visit charge. If we are unfamiliar with the reimbursement plan for your insurance company, *we reserve the right to request that you pay for services in full.* In the event that your insurance company then pays for these services, you will receive your choice of a credit at the clinic or a check for the amount paid by the insurance company. Since insurance companies will not pay for non-pharmaceutical medicines as well as many injections and physical medicine procedures, you will be expected to pay for this part of the treatment plan at the time of service.

2. If you would like to apply for a special payment plan, please discuss this with us *before your scheduled appointment*. We do accept Master Card, Visa and Debit Card payments.

3. Phone consults are billed at the *same rate as office visits*. Any phone conversation lasting more than 5 minutes will be charged accordingly.

4. *A 24 hour cancellation notice must be given* or your account will be charged a $25 fee.

5. All statement balances are due upon receipt, and any amounts past 30 days will be charged a *1.5% interest fee* for delayed remittance. All accounts not paid within 90 days of the date of service will be sent to collections. Returned checks are subject to an additional charge of $20.00 in order to recover bank fees.

To indicate that you have read and understand these policies, please sign below:

Name: _____ Date: _____