BASIN
NATURAL MEDICINE
Transforming Health Naturally

Jan Polson, DAOM, LAc.
FINANCIAL POLICY

Thank you for choosing **Basin Natural Medicine, Inc.,** as your health care provider. I am committed to your treatment being successful. Please understand that payment of your bill is considered a part of your treatment. The following is a statement of my Financial Policy which I require you read and sign prior to any treatment. All patients must complete an Information and Insurance form before seeing the doctor.

I ACCEPT: Cash, check, some types of insurance plans, cash discount will be extended for payment in full at the time of service.

Regarding Insurance
I may accept assignment of insurance benefits after your first visit. However, I do require the designated co-pay to be paid at time of service. The balance is your responsibility whether your insurance company pays or not. I cannot bill your insurance company unless you give us your insurance information. Your insurance policy is a contract between you and your insurance company. I am not a party to that contract. If your insurance company has not paid your account in full within 45 days, the balance will be automatically be transferred to an extended payment plan. Please be aware that some, and perhaps all, of the services provided may be non-covered services and not considered reasonable and necessary under the Medicare Program and/ or other medical insurance.Regarding Insurance Plans where I am a participating provider, all co-pays and deductibles are due prior to treatment. In the event that your insurance coverage changes to a plan where I am not participating provider, refer to above paragraph.

Usual and Customary Rates
My practice is committed to providing the best treatment for my patients and I charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Adult Patients
Adult patients are responsible for full payment at time of service, unless I am billing your insurance.

Minor Patients
The adult accompanying a minor and the parents (or guardians of the minor) are responsible for full payment. For unaccompanied minors, non-emergency treatment will be denied unless payment arrangements have been made prior to the appointment.

Missed appointments
Unless canceled, at least 24 hours in advance, my policy is to charge for missed appointments at the rate of **$50.00.**
Please help me to serve you better by keeping scheduled appointments.

Thank you for understanding my Financial Policy. Please let me know if you have questions or concerns.
I have read the Financial Policy. I understand and agree to this Financial Policy:

_____ _____
Signature of Patient or Responsible Party Date

EMAIL FORM
PRINT FORM