

Laurie Marzell, N.D., N.C.M.P.

15962 Boones Ferry Rd #102, Lake Oswego, OR 97035 ♦ Phone: 503-655-9493 ♦ Fax: 503-699-1847

OFFICE, FINANCIAL, AND INSURANCE POLICIES AGREEMENT

We are committed to providing you with the best possible health care.

If you have medical insurance that covers naturopathic care, we will be happy to bill them. Please refer to your insurance policies for specific coverage. Your insurance coverage is a contract between you and your insurance company. You are ultimately responsible for payment of your account. Please provide us with complete insurance information and inform us of any changes in your insurance, address, telephone number. If you do not have insurance or request that we do not bill your insurance, payment is due in full at the time of your appointment.

Being able to evaluate a patient in person is often essential for adequate care. We are able to schedule occasional telephone appointments for patients who are unable to accommodate a visit to the office. These appointments can be billed to your insurance but may not be covered.

Any unpaid balances are your responsibility and after 60 days will incur a monthly charge of 5% of your balance. This is not a one time charge, but a recurring charge that will be added for each additional 30 days. Any remaining unpaid balances 150 days past date of service will be referred to collections.

We understand financial hardship may affect timely payments for services. We encourage you to contact our office promptly to make payment arrangements.

Missed or cancellation of an appointment with less than 48 business hours notice will be billed as a regular office visit to the patient. Insurance will not cover these charges.

A \$30.00 NSF fee will be charged for any returned checks.

“I have read the above information and agree that, regardless of my insurance status, I am responsible for the balance of my account. I also agree to the above terms and conditions.”

Signature: _____ Date: _____

“I hereby authorize the release of any medical or other information necessary to process insurance claims for services provided to Laurie Marzell, ND. This release of information expires one year after termination of care. I hereby authorize and direct my insurance carrier(s), including private insurance and any other health/medical plan, to issue payment check(s) directly to Dr. Laurie Marzell otherwise payable to myself and/or my dependents regardless of my insurance benefits.”

Signature: _____ Date: _____