( ) Dr. Stacy Bowker, ND
( ) Dr. Theresa Martez, ND, LMP
Naturopathic Advantage

SNOHOMISH VALLEY HOLISTIC MEDICINE

( ) Charleen Van Horn, Lac, LMP
( ) Gyda Harris, LMP, BT
( ) Mary-Ann Zenger, LMP

1830 Bickford Avenue, Ste. 201 Snohomish, WA 98290 Phone: (360) 282-4014 Fax: (360) 282-4017

Acknowledgement of Receipt:

Financial Policy

The following is our Financial Policy. Please review it carefully and then sign and date it.

- Payment is due at time of service. In special circumstances, the provider may arrange differently. Acceptable forms of payment include cash, checks, and Visa & MasterCard credit cards. Insurance is also accepted (see below).
- Patients who pay out of pocket will be given a 25% discount for Payment at Time of Service.
- All nutritional supplements must be paid for at the time of purchase, regardless of insurance coverage.
- Please give notice if you cannot keep an appointment. This courtesy will allow others to be seen. Failure to give at least 48 hours advance notice for appointment cancellations may result in a fee.
- Some services, including phone and e-mail consultations, may not be covered by health insurance benefits. Patients who initiate phone or e-mail consultations may be charged for the provider's time at the discretion of the provider.
- Patients are responsible for all bank charges and fees resulting from a returned check.
- Accounts more than 60 days overdue will incur financing charges of 1% per month on any outstanding balance.

Insurance: Your insurance policy is a contract between you and your insurance company. We are not a party to that contract. We will bill your insurance companies for which we are contracted providers, as long as you provide us with your current and correct information.

I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any balance. I also authorize my provider or my insurance company to release any information required to process my claims. I understand that payment is dependent on my eligibility at the time of service and ALL terms and conditions of my insurance plan. I also acknowledge that certain services may not be covered by my benefit plan, or deemed medically unnecessary, and agree to pay for any Non-Covered Service, such as phone or e-mail consultations and outside labs. This authorization shall remain valid until revoked by me in writing.

Payment issues: If financial problems arise, please contact our office as soon as possible. Installment or payment arrangements can be implemented. However, if you or the person financially responsible does not adhere to the payment plan, the balance will become due immediately.

I have carefully read the Financial Policy. I understand and agree to the terms therein,

______________________________ ________________________
Signature of Patient or Responsible Party Date

____
Print Name

____________________________ ________________________
Patient Name Date of Birth

Revised: 12/14/2009

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Acknowledgement of Receipt:

Notice of Privacy Practices

- I have been offered a copy of the Notice of Privacy Practices for the Practitioner that I am seeing. For future reference I may access a copy at the front desk or on the web-site.

______________________________ __________________________
Signature of Patient or Responsible Party Date

Acknowledgement of Confidentiality:

- **Voicemail:**

I hereby give permission for Snohomish Valley Holistic Medicine to leave the following on my voicemail:

- o Detailed medical information
- o Limited medical information (please specify with your provider)
- o Billing and appointment information

______________________________ __________________________
Signature of Patient or Guardian Date

- **E-Mail:**

I hereby give permission for Snohomish Valley Holistic Medicine to leave the following on my e-mail:

- o Detailed medical information
- o Limited medical information (please specify with your provider)
- o Billing and appointment information

______________________________ __________________________
Signature of Patient or Guardian Date

______________________________ ______________________________
Patient Name Date of Birth

Revised: 12/14/2009