Katherine Reinholtz, N.D.
NATUROPATHIC MEDICINE

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STATEMENT OF FINANCIAL RESPONSIBILITY

I understand and agree to the following general responsibilities:

I am responsible as the patient or patient's guarantor for full payment of services rendered at the time of service, including medicinary items and laboratory work. I am responsible for providing all accurate and thorough documentation required to support any discounts I am receiving. I acknowledge that I am financially responsible for all charges.

I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, I agree to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize my Dr. Katherine Reinholtz, ND to release information necessary to secure payment.

There will be a flat fee of $50 for any naturopathic appointment not cancelled within 24 hours of that appointment.

I understand and agree that my doctor practicing naturopathic medicine operates as a cash based practice and does not accept any form of insurance. A super bill will be provided per visit with all necessary information in order for the patient to submit for insurance re-reimbursement. Dr. Katherine Reinholtz is not responsible for ensuring insurance reimbursement.

I have fully read and understand the above agreements and authorizations.

_____ _____

Patient (18 years or older) Date

_____ _____

Parent, Guardian, Responsible Party Date