WELLNESS GARDEN
Integrative Medical Clinic
Wellness-Garden.org ◆ 2205 W Woodin Ave / PO Box 2308, Chelan, WA 98816 ◆ (509) 888-7370

FINANCIAL POLICY

Welcome to Wellness Garden. Our mission is to facilitate health and wholeness through East Asian Medicine. Each client is treated as an individual with their overall health & wellness as our first priority. Thank you for choosing our practice.

Our financial policy is designed to help treat all clients equally and fairly. We've learned from experience that clear communication to avoid any potential problems later on in our relationship. Please read the following carefully.

Co-payment is due at the time of services. **We accept cash and checks.**

In the event of records requests, all balances are required to be paid in full at the time of records requests being processed. In addition, there is a fee for copying and processing of records requests.

We are more than happy to process your insurance billing for you. Please remember that insurance policies are a contract between your insurance company and yourself**. In the event your insurance company denies payment you will be responsible for the balance due.** If, during the course of your treatment, there are changes in your policy, please notify us as soon as possible to avoid any potential billing problems.

I authorize the release of any medical or other information necessary to process claims. I also authorize payment of government benefits either to me or to the party who accepts assignment in Box 27 of the CMS 1500 form on which claims are submitted on my behalf. This will be retroactive to your first date of service.

Missed Appointments:

Please cancel you appointments 24 hours in advance so we may be able to offer the space to someone waiting to be seen.

No Shows: Not calling to cancel and not showing up for your appointment is considered a "no-show". A one-time courtesy will be given for a no-show, after that you will be billed $65.00 no show fee, second time you will be charged your full visit fee for your no-show appointment.

We appreciate your understanding and courtesy in regards to missed appointments.

I acknowledge that I have read, understand, and agree to the above financial policy.

Patient Signature: _____ Date: _____

Printed Name: _____