Naturopathic
Health Center, LLC
415 Howe Avenue Suite 307 Shelton, CT 06484

Financial Policy

Thank you for trusting Naturopathic Health Center, LLC, where we are committed to providing the best naturopathic and holistic health care possible. Please understand that the payment of your bill is considered part of your treatment. The following statement explains our financial policy. Please read the policy, sign and return it to us prior to your treatment.

I, _____, understand I am responsible for payment of any charges and agree to pay Naturopathic Health Center, LLC, the regular charges for all medical services rendered to me. It is my responsibility to pay my bill. If I do not pay my bill, I agree to pay Naturopathic Health Center, LLC, any collection costs they may incur, including attorney fees. Naturopathic Health Center, LLC, reserves the right to accept periodic installment payments without waiving their right to demand payment in full.

If you have an insurance provider, we will provide you with a superbill that you can send to your insurance provider for reimbursement if you have out-of-network benefits, but we expect you to pay our bill and collect the insurance proceeds yourself.

Returned Checks
For checks returned to us as unpaid by your bank, you will be charged a $25.00 fee.

Missed Appointments
Please provide at least 24 hours notice of cancellation as a courtesy. Our policy is to charge $25.00 for missed appointments without appropriate notice. Please help us to serve you better by keeping scheduled appointments.

I understand that I am financially responsible for the charges that I incur during my treatment under the care of the Naturopathic Health Center, LLC. This includes all naturopathic therapies, supplements and office visits charges. I have read and agree to the financial policy.

Signature of Patient _____ Date _____

Name of Guardian _____ Relationship _____

Signature of Guardian _____ Date _____