

Dear New Patient,

Welcome to Bambú Clinic. We look forward to providing for your health care needs. We encourage your questions and participation in all aspects of your care. Please read and initial the following statements:

_____ Payment for all services and medicinary items is due at the time of the visit. We accept cash, checks, Visa and MasterCard. Returned checks will be subject to a \$35.00 NSF fee.

_____ Courtesy insurance billing is provided by Dr. Asmar and Dr. Caldwell if you have naturopathic coverage. If you have verified your insurance, you may pay your co-pay/percentage/deductible at the time of service. Once payment is received from the insurance company, you will be billed or credited for the remaining balance. You must verify your insurance coverage in advance of your appointment, using the "How do I verify my insurance" form.

_____ Phone calls and emails regarding an existing health issue that require more than 10 minutes of attention from your physician will incur a fee. Phone calls and emails regarding a new health issue, regardless of the length of time of attention required, will also incur a fee. Your physician will notify you of the need for a charge, so that you can determine whether you would like to address the issue and pay the fee, or schedule an appointment. Phone and email charges are not billable to insurance.

_____ You will be charged a Missed Appointment Fee of \$50.00 for any missed appointments or late cancellations (less then 24 hours notice).

_____ Paying more than my co-insurance would present a financial hardship.

_____ I understand that I am expected to have a local primary care physician if I am conducting my appointments with my Bambú Clinic practitioner(s) by phone, Skype, or any other electronic means.

Your health care provider may prescribe medication, which may be purchased at Bambú Clinic or elsewhere. Most insurance companies do not cover the pharmacy items that we prescribe and dispense.

I have read and understand the above-stated policies of Bambú Clinic and will comply with them in all respects. If my insurance company requires release of my medical records, I hereby give my permission by signing this form.

Patient Name (Please Print. Include parent/guardian name if patient is a minor.)

Patient Signature (Parent/guardian signature if minor)

_____/_____/_____
Date