The Whole Woman, PLLC

FINANCIAL POLICY

APPOINTMENTS

The keeping of regular appointments is crucial to successful therapy. As schedule permits, we will work out a most convenient time for you for these appointments. The scheduling of an appointment constitutes an agreement to pay for the professional time reserved exclusively for you.

_____ **Our policy is to charge for missed appointments or appointments canceled with less than 24 hours notice of the reserved appointment. You will be billed $150 directly for this time.**

PAYMENT OF FEES

_____ **The Whole Woman does not participate with any insurance plan nor do we file on your behalf.** We will provide you with all necessary paperwork to assist you in filing with your insurance company. Payment to The Whole Woman is to be made in full at the time of service. We accept cash, check, and credit card. Payment of any unpaid balance on an account must be received in full before the close of the month. Payments are non-refundable. You will be charged a $25 service charge for all returned checks. Unpaid balances older than 90 days will be subject to collections proceedings. This process includes the addition of a thirty-three and one-third (33 1/3) percent attorney fee to your unpaid balance. Service may be interrupted until payment is made.

_____ **I have received a copy of the basic fee schedule.**

_____ **I am not a Medicare or Medicaid patient.**
By signing this, you are informing our office that you are not a Medicare or Medicaid patient. If you are a Medicare or Medicaid patient, please inform our front desk staff.

REPORTS, CONSULTATIONS AND OTHER CLERICAL MATTERS

_____ **Any reports or professional consultations involving time beyond that of the regular appointment will be billed at a pro-rated charge for the professional time involved.**
_____**We will charge for telephone, email and/or communication consultations with your provider, which are longer than five minutes, at the usual and customary rate.**

READ CAREFULLY AND SIGN

I have read, understand, and agree to comply fully with the above policies. I recognize and accept full financial responsibility for all professional services rendered.

_____ _____

Signature of Patient/Responsible Party Date

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