Whole Health Wellness Center
120 Simsbury Road - Suite B, Avon, CT 06001 Phone (860) 674-0111 ~ Fax(860) 677-5406

Financial Policy Disclosure

Examinations vary in price depending on complexity and number of body systems that are examined. Some of our current fees for common services are as follows:

Naturopathic Consultation / Examination	
New patient office visit	$200 - $300
Established patient office visit	$100 - $150
Preventative/Nutritional Counseling	$70 - $200
Treatments/Procedures	
InBody	$ 20
TeleHealth/Phone Consult	$ 75 per 15min
	$150 per ½ hr
RedLight Therapy – Single Session	$ 55
10 Session Package	$350

Chiropractic Care	
New Patient Office Visit	$100 - $200
Established patient office visit	$ 65 - $150
Adjustment 1-2 Regions	$ 58
Adjustment 2-3 Regions	$ 60
Adjustment 5 Region	$ 80
Adjustment extremity	$ 50
Electric Stim	$ 25
Manual therapy	$ 50
Neuromuscular Reeducation	$ 50
Therapeutic Exercise	$ 50
Traction	$ 25
Ultrasound	$ 30
Acupuncture - **when** not covered by insurance:	$ 68
12 Treatment Package	$748

Photocopy fee: 65¢ per page

Payment is due on the date of service unless other arrangements have been made. We accept cash, money orders, cashier's checks, personal checks, and credit cards.

CANCELLATION POLICY – When you call and schedule an appointment, time is reserved especially for you and no one else. Since the appointments are much longer than standard medical office visits, cancelations are significant interruptions to the office. Therefore, we require you to give our office twenty-four (24) hours' notice when canceling an appointment or you will be charged a $50 penalty fee. ***Initials*** _____

MISSED APPOINTMENTS – You will be charged a $50.00 penalty fee. ***Initials*** _____

SPECIALTY LABORATORY TESTING – Our office frequently uses specialty testing. These are often an out-of-pocket expense. Occasionally, these are covered by your insurance.

I have read the above fees and policies and understand the cost of my care. I understand that I am responsible for payment of all deductibles and co-payments related to my care. I understand my insurance company is billed as a courtesy, and I further understand that I am responsible for any amount that my insurance company does not pay. **I am aware Whole Health Associates cannot guarantee my insurance will cover my visits and I should call my insurance carrier to confirm my policy coverage and ask if I have any exclusions for my visits.** ***Initials*** _____ **I have confirmed with my insurance company that I do or do not need a referral or preauthorization for my visits, and I have notified Whole Health Associates, LLC.** ***Initials*** _____ If my balance is not paid in a timely and monthly fashion, or based on a written and signed agreement, I promise to pay any and all collection, court and attorney fees related to the collection of my account. I understand that if my treatment is associated with a personal injury or accident claim, all medical bills need to be paid at 100% of the above fee schedule regardless of the outcome of my case. I understand that if a check or credit is returned for insufficient funds, I will be charged a $40.00 service charge. I understand and agree to the terms and conditions of the above Financial Policy.

SIGNATURE_____DATE_____