Whole Health Wellness Center
120 Simsbury Rd, Suite B Avon, CT 06001 - 860-674-0111

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 - $324
Established patient office visit	$100 - $167
Preventative/Nutritional Counseling	$70 - $200
Prolonged Service Same Day 15 Min	$70
Prolonged Service Separate Day 30 Min	$140
TeleHealth/Phone Consult 15 Min	$75
TeleHealth/Phone Consult 30 Min	$150

Treatments/Procedures Not Covered by Insurance

InBody	$20

Biofeedback - Independent of Appointment	
Single Session - 20 min	$75
Biofeedback - 5 Pack	$300

Redlight Therapy - 15 Minute Sessions	
Single Session	$60
6 Session Package	$360
10 Session Package	$399

Membership:

9 visits per month*	$360

* Auto debit agreement required - ask for details

Chiropractic Care	
New Patient Office Visit	$100 - $200
Established patient office visit	$ 65 - $150
Prolonged Service Same Day 15 Min	$70
Prolonged Service Separate Day 30 Min	$140
Adjustment 1-2 Regions	$58
Adjustment 2-3 Regions	$68
Adjustment 5 Region	$80
Adjustment extremity	$58
Electric Stim	$50
Manual therapy	$58
Neuromuscular Reeducation	$60
Therapeutic Exercise	$60
Traction	$50
Ultrasound	$50
Self Care/Home Mgmt Training	$68

Acupuncture - Insurance Rate	$75

Acupuncture - If not covered by insurance	
Single Treatment	$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, cancellations are significant interruptions to the office. Therefore, we require you to give our office twenty-four (24) hours' notice when cancelling 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 Wellness 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 Wellness, 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. ***Initials*_____**

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. ***Initials*_____**

I understand that if a check or credit is returned for insufficient funds I will be charged a 40.00 service charge. ***Initials*_____**

Rates are subject to change at any time. Our most current Policy is available at www.wholehealthllc.com

I understand and agree to the terms and conditions of the above Financial Policy.

PATIENT NAME_____

PATIENT SIGNATURE_____DATE_____

Revised 6/1/2021