Whole Health Wellness Center
231 Farmington Ave Suite 201, Farmington, CT 06032 (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:

	Insurance Rates	**Out of Pocket Rates (if not covered by Insurance)**
Naturopathic Consultation /		
New patient office visit	$200 - $463	$180 - $415
Established patient office visit	$139 - $345	$125 - $310
Preventative/Nutritional Counseling	$75 - $300	$68 - $270
Prolonged Service Same Day 15 Min	$70	$63
Prolonged Service Separate Day 30 Min	$140	$126
Craniosacral Therapy/Visceral	$58	$52
Acupuncture	$95	$80
Chiropractic Care		
New Patient Office Visit	$140 - $295	$126 - $266
Established patient office visit	$65 - $180	$58 - $162
Adjustment 1-2 Regions 98940	$68	$61
Adjustment 2-3 Regions 98941	$72	$65
Adjustment 5 Region 98942	$80	$72
Adjustment Extremity 98943	$62	$56
Electric Stim	$50	$45
Manual therapy	$58	$52
Neuromuscular Reeducation	$60	$54
Therapeutic Exercise	$65	$58
Traction	$50	$45
Ultrasound	$50	$45
Self Care/Home Mgmt Training	$68	$61
Graston Technique	$58	$52
Dry Needling 1-2 Muscles	$50	$45
Dry Needling 3 Muscles	$60	$54
Acupuncture	$95	$80
Medicare: Chiropractic New Patient visits are not covered by Medicare - Patient is responsible		$130

Patients with no insurance, limited benefits or high deductible should ask about *ChiroHealth USA* Medical Discount option

Treatments/Procedures Not Covered by Insurance

Acupuncture - (May be covered by Ins)	
Single Treatment	$80
6 Treatment Package	$448
12 Treatment Package	$880
Bioresonance Therapy	
30 Minute Session	$95
60 Minute Session	$190
Cupping (97140)	$52
Dry Needling - (May be covered by Ins)	
1-2 Muscles	$45
3+ Muscles	$54
Graston Technique	$52
InBody	$30
Laser Therapy (Class IV) - 15 Min Sessions	
Single Session	$70
8 Session Package	$499

Massage Therapy	
Single Session 60 Minute	$115
Single Session 90 Minute	$145
Massage Therapy Packages	
6 Sessions 60 Minute	$660
12 Sessions 60 Minute	$1,265
6 Sessions 90 Minute	$840
12 Sessions 90 Minute	$1,595
Personal Training	
Single Session 30 Minute	$45
Single Session 60 Minute	$75
Online Coaching	$150
Personal Training Packages	
6 Sessions 30 Minute	$246
12 Sessions 30 Minute	$468
6 Sessions 60 Minute	$426
12 Sessions 60 Minute	$828
Redlight Therapy - 15 Min Session	
Single Session	$42
12 Session Package (1st Package)	$399
12 Session Package (2nd Pkg on)	$350

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 these 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 1/1/2026