

Chris Booren N.D.
1820 SW Vermont Street Ste. G Portland, OR 97219
(503) 246-3919

Office, Financial and Insurance Policies

We are committed to providing you with the best possible healthcare.

If you have medical insurance that covers Naturopathic services, we will be happy to assist you in submitting your insurance claims. I hereby authorize Dr. Chris Booren to bill my charges through my primary and then, if applicable, secondary insurance plans. I understand that, in some cases, care provided to me by Dr. Booren, although agreed medically indicated by her and I, may not be covered by either plan. In this instance, I agree to pay any balance owed. Please submit your insurance information as soon as possible to our office so that we may determine your coverage. Knowing the details of your coverage ahead of your visit may save time, money and frustration.

Payment is due at time of service.

We request lab work that is medically necessary to determine your health needs. If these are not covered by your insurance it will be your responsibility to pay any lab fees.

Supplements are not covered by insurance companies. We will need you to provide payment for those items at the time you pick them up or when you order them over the phone.

We understand that, on occasion, temporary financial problems may affect timely payment of your account. If such problems do arise we encourage you to contact our office promptly and make arrangements. We will be happy to set up payment arrangements, or answer any questions concerning your insurance reimbursements. A finance charge of \$.50 will be imposed on your account if it has not been paid within 30 days of your appointment unless you have established a payment plan and are current with your monthly payment. An additional \$7.00 penalty fee will be added each month if we need to call, rebill or otherwise remind you of your delinquent account. We accept cash, checks, debit, visa, and master card. There is a \$37.00 charge for returned checks.

As a courtesy to other patients requiring services, we request that you provide notice of cancellation 24 hours in advance. Persons missing appointments will be charged a fee of \$50.00 unless we are notified.

If you have any questions concerning the above information or any uncertainty regarding insurance coverage, please don't hesitate to ask. We appreciate your patronage and are glad to be of service to you.

~~~~~  
I have read the above information and agree that, regardless of my insurance status, I am responsible for the balance of my account. I agree to make payment on my account, as discussed above, and to notify this office should there be any change in my insurance coverage. I also understand that Dr. Booren may order tests which are not covered by my insurance company, and I will be responsible for those fees.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

I authorize the release of any medical or other information necessary to process this claim. I also request payment to be made directly to Dr. Booren.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_