

Washington Homeopathic Clinic

1813 115th Ave NE, Bellevue WA 98004
425-881-8929 admin@wahomeopathy.com

Ryan Robbins ND DHANP

Fees and Services Waiver

Patient Full Name: _____

Guardian Full Name (if applicable): _____

Initial Constitutional Assessment Visit *	\$725 (\$225 insurance billable portion)
Primary Care Intake Visit	\$225
Follow-Up Visits	\$90-\$160
Acute Visit (brief)	\$125
After-hours Page *	\$90
Late cancellation/No Show *	\$50
Homeopathic Medication *	\$10-30 each

* *Not billable to insurance*

Lab Charges – Most labs are billed directly to your insurance. Occasionally some labs bill our office and in that case, the clinic will invoice you.

Billing Statements

Statements are sent via email or patient portal. It is the patient/guardian's responsibility to promptly make payments, and to keep the clinic up-to-date on changes to personal data, such as physical mailing address, phone numbers, email address, as well as insurance ID# and subscriber information.

Insurance Payment for Services

The initial constitutional assessment (\$500) is an out-of-pocket expense and cannot be submitted to insurance for reimbursement. The constitutional evaluation exceeds the time and content limitations set by insurance companies, and insurance carriers consider it investigational. We will bill your insurance company for the medical portion of your care as appropriate.

Health insurance is an agreement between you and your insurance company. You are responsible for contacting your insurance carrier regarding coverage for treatment. Please verify if the doctor is contracted with your insurance company at this practice and whether your insurance plan covers naturopathic medicine.

If the insurer requires a referral you must have this paperwork completed prior to the visit and we must receive a copy prior to treatment. Our office bills only insurers with whom we have contracted (see list on our website). For all others, payment is required at the time of service.

I have read and agree to the above information and assume responsibility for charges incurred from treatment by Ryan Robbins ND. I authorize my insurance company to pay physicians at this clinic for services rendered. I agree to pay for services regardless of the insurance company's determination of benefits. I acknowledge that I am responsible for payment of all patient charges if I do not have insurance.

Patient (or Guardian) Signature

Date