Washington Homeopathic Clinic
2025 112th Ave. NE, Suite 300, Bellevue WA 98004 Ryan Robbins, ND, DHANP
425-881-8929 admin@wahomeopathy.com

Fees and Services Waiver

Patient Full Name: _____

Guardian Full Name (if applicable): _____

First Office Visit

Constitutional Assessment *	$500
Medical Assessment	$225
Total First Visit Charge	**$725**

Other Appointments and Charges

Follow-Up Visit	**$160** (up to $335 for extended visits)
Acute Visit (sore throat, cough, fever, etc.)	**$125**
Phone/Telemedicine Appointment	$90-$160
After-hours Page Fee *	$90
Late cancellation/No Show Fee *	$50
Homeopathic Medication *	$10-30 each

** Not billable to insurance*

Lab Charges – Most labs will bill directly to your insurance. Occasionally some labs will bill directly to the doctor. In that case, a separate bill will be sent to the patient from the Clinic.

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 at Washington Homeopathic Clinic. 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**