

## CLINIC POLICIES AND FINANCIAL STATEMENT

- \* Services and therapies offered by Dr. Anita Bratt are considered “complementary” and are not covered by MSP. The exceptions are patients on MSP premium assistance who are eligible for the partial reimbursement of consult fees.
- \* Some extended health care plans may reimburse patients for services. It is the patient’s responsibility to check with their insurance carrier regarding eligibility for coverage. Our office cannot submit bills directly to insurers.
- \* We accept payment by cash, cheque, debit, Visa and Mastercard. There is a \$45 fee for any NSF cheques returned.
- \* Any supplements which have been opened cannot be returned for refund.

### Cancelled & Missed Appointment Charges

#### New Patients

Two business days are required to notify the clinic of any cancellation or rescheduling. Failure to do so will result in a \$100 cancellation fee.

#### Return Patients

Cancelled or missed appointments with less than 48 hours notice will result in a \$50 charge.

#### Phone Call Policy

Dr. Bratt understands that you may have questions after your office visit. However, due to time constraints, phone calls longer than 5 minutes about current treatment or conditions will be billed as a consultation. **Phone calls regarding new symptoms or treatments will be billed as a consultation, regardless of length.**

#### Email Policy

Email is generally not an effective way to communicate regarding patient care. We accept emails only relating to the scheduling of appointments, re-ordering of supplements, and basic clarification questions about current treatment plans. **Questions about any new symptoms or treatments must be addressed by phone consult or office visit only.**

- \* By signing below, I certify that I understand and agree to comply with the above stated policies. I acknowledge financial responsibility for all charges due at the time of service. This includes consultation fees, supplement costs and lab tests ordered. Please retain a copy for your records.

Patient Name: \_\_\_\_\_

Parent’s name (if patient is a child) \_\_\_\_\_

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