Children's
Homeopathic
Clinic
2814 S Grand Blvd.
Spokane, WA 99203
(509) 456-2570
www.childhomeopathy.com
Michael Baker, ND, MS, DHANP
Molly Keys, ND

Fees and Services Not Covered By Insurance
Waiver and Explanation

PLEASE READ CAREFULLY. IF YOU DO NOT FULLY UNDERSTAND PLEASE ASK STAFF FOR FURTHER EXPLANATION.

Patient ____ **Date** ____________________

Guardian Name (if applicable) ____________________________

First Office Call (up to 2 hrs)

- Constitutional Assessment Fee (out-of-pocket expense) $325
- Medical Fee (billable to insurance if available) $175
- Total (excluding medications) $500

Acute (20 min) $90
Return Office Call (30 min) $125
Extended Return Visit (40 min) $155
Homeopathic Medications $15

_____**Insurance Payment for Services**

The constitutional evaluation exceeds the time and content limitations set by insurance companies. Your insurance carrier considers a portion of the information gathered to be medically unnecessary and investigational. We will bill your insurance company for medically necessary services as appropriate. We routinely bill insurance companies for a portion of the first office call..

_____**Payment for Outside Labs**

Your insurance carrier may or may not cover all charges for either the test or the laboratory we choose. We appreciate payment for labs before the test is submitted.

_____**Cancellation Fee**

A $100 deposit is required for all first time appointments. This deposit is refundable only if three-business days notice are given for cancellation or change of date. We also require one business day's notice for a return visit (i.e. you must notify us by Friday morning for a Monday cancellation). For return patients, we reserve the right to charge a $50 late cancellation fee.

I have read the above and agree to assume responsibility for charges incurred from treatment at Children's 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.

____ ____________________
Signature of Patient or Guardian Date

Payment is expected at time of service. Thank you.