Boulder Natural Health, LLC
1120 Alpine Ave. Suite E, Boulder, CO 80304
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www.bouldernaturalhealth.com

Financial Policy

Payment: Payment for office appointments, supplements and lab tests are due in full at the time of service and/or purchase. For payment we accept cash, Visa or Mastercard. Many insurance companies now reimburse for naturopathic or alternative medical care. Please check your individual coverage to find out more about your benefits and limitations. We do not take insurance cards or bill insurance in our office. For your convenience, we will provide you with a "superbill" for you to submit to your insurance company for reimbursement at the time of service.

Delinquent Accounts: If a check is returned due to insufficient funds, there will be a $30 charge added to your account. If payment is not received within 30 days, finance charges will begin accruing at 1.5% per month. Excessively overdue accounts will be forwarded to an outside collection agency.

Cancellations: We require a minimum 24-hour cancellation notice. Charges up to the full visit fee apply to all non-emergency cancellations with less than 24 hours notice.

Fees: All fees are based on time. Office visit rates are $60 per 30 minutes.

New Patient Adult (90 minutes) - $180
Follow Up (45 minutes) - $90
New Patient Child (60 minutes) - $120
Acute Care (30 minutes) - $60

*Telephone calls greater than 20 minutes are payable at standard office rates.
*Lab charges vary based on the type of test. Payment for lab tests that is not covered by insurance is due at the time of service.

Supplements: During the course of care, we may recommend certain natural medicines. You have the option of purchasing these supplements at our office or outside the clinic. Payment for supplements is always due at the time of service. Supplements are nonrefundable unless they are unopened and returned within 30 days of purchase.

Discounts: A sliding scale is available for patients with low income. Please ask for more details. A 10% discount is available when prepaying for 4 or more visits at one time.

I understand that I am financially responsible for all charges and agree to abide by this financial policy.

Patient/Guardian Signature:________________________ Date:_______