Terms of Agreement

Patient Name: Last____________________ First_________________________________

Age: ________ DOB: ___________ Social Security Number: _____-____-_____

Welcome to the Freeze Naturopathic Care and thank you for selecting us for your healthcare needs. We look forward to helping you along the way to great health.

Office Hours: Please note our office hours will vary, as will the days during the month that we are available in the office. However the days we are not in the office, we will be available by phone or/and email, on normal business days.

Cancellation: Please give at least 24 hour notice to reschedule an appointment. Failure to cancel an appointment without giving the clinic a 24-hour notice will result in a full charge of your appointment.

Fees & Financial Policy: Payment of fees is the direct responsibility of the patient. We shall collect payment for services and products at the time of visit. We accept cash, check, Visa, MasterCard and Discover as forms of payment.

Insurance Billing: We do not bill insurance and fees are due at visit.

Medicinary: To pick up refills of your medicinary items, please call the center 24hrs in advance so that any waiting time can be minimized. We will ship supplements to you. A charge of $5.00 will be applied or shipping. Please note orders of $75.00 or more will not have a shipping fee.

Terms: All of our fees are subject to change without prior notice. Past due balances are subject t o a 2% per month (18% per annum) service charge, plus a monthly billing charge of $10.00.

Statement: I have read and understand the above policies of Freeze Naturopathic Center PLLC and agree with them. I consent to the treatment with Dr. Karen Freeze, N.M.D and accept full responsibility for all expenses incurred by or on the account of the patient. In the event of non-payment, I will bear the cost of collection and/or all court costs and legal fees should it be required. I authorize the release of any medical information necessary to process an insurance claim and authorize payment directly to the signed physician. Due to the new privacy policies, this form must be signed to disclose your private health information.

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Signature if Patient and/or Guardian Date: