DR. MAURA
NATUROPATHIC DOCTOR

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Statement of Financial Responsibility

I understand and agree to the following general responsibilities:

I am responsible as the patient or patient's guarantor for full payment of services rendered at the time of service, including medicinary items and laboratory work. I am responsible for providing all accurate and thorough documentation required to support any discounts I am receiving. I acknowledge that I am financially responsible for all charges.

I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, I agree to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize my Dr. Maura Henninger, ND to release information necessary to secure payment.

There will be a flat fee of $25 for any naturopathic appointment not cancelled within 24 hours of that appointment.

I understand and agree that my doctor practicing naturopathic medicine operates as a cash-based practice and does not accept any form of insurance. Dr. Maura Henninger is not responsible for ensuring insurance reimbursement.

I have fully read and understand the above agreements.

_____ _____
Signature (Patient 18 years or older) Date

_____
Parent, Guardian, Responsible party

_____
Please print name