OLYMPIA NATURAL MEDICINE

Karyn White, ND

520 Lilly Rd. NE Bldg. 2 Olympia, WA 98506

Phone 360-357-7902 Fax 360-688-7607

Financial Policy

Please read and sign below:

Office Visits: The cost for a first office visit is $175-$190 and return office visits are $90-$120. Additional charges may be applied for procedures. Prices are subject to change without notice.

Medications: Prescription supplements and herbal medications are not covered by insurance. Payment in full is expected at time of service. Special orders need to be paid for in advance. I am unable to accept returns. There is no requirement to purchase medications from my office.

Methods of Payment accepted: cash, checks, Visa, and Mastercard. We understand that financial circumstances may affect timely payment of your account, please contact our office to make payments arrangements as needed. There will be a $50 fee for returned checks.

Insurance: I am currently contracted with Regence, Regence Blue Shield, Regence Uniform Medical, Premera, First Choice, Kaiser Options, Coordinated Care/Ambetter, Aetna and Cigna. Not currently accepting new patients for Aetna and Cigna. Coverage is not guaranteed, please contact your insurance company to verify coverage under your current plan.

Late cancellations and missed appointments: 24-hour notice is required to cancel an appointment. Appointments cancelled or missed without 24-hour notice will incur a fee of $50. New patients who miss their first appointment without 24-hour notice will not be rescheduled. Current patients who miss 2 appointments without 24-hour notice will incur an additional fee and will be discharged from the practice.

Reminders: As a courtesy, we both call and email appointment reminders. You are responsible for remembering your appointment, if you do not receive these reminders fees will still apply.

Please contact our office if you have any questions about these policies. We appreciate that you have chosen Olympia Natural Medicine and Dr. White for your healthcare. We are glad to be of service to you.

Authorization: I have read the above information and agree, regardless of my insurance status, to be responsible for the balance of my account. I agree to pay for all services rendered but not covered by insurance.

Patient or Authorized Person’s Signature Printed Name Date