

FEE SCHEDULE

For the office to run efficiently and serve you best, we ask that you understand that your appointment is set aside and personalized for you. As such, **we require 24 hours notice if you intend to cancel an appointment.** If you must miss a treatment without proper notice, you will be required to pay the full fee for the missed appointment, except in the case of inclement weather or a true emergency.

Initials

Office Visits:

Adult Consultation	
Initial Consultation (up to 60 minutes)	Initial Consultation \$200
2 nd Visit (30 minutes) <i>The first two visits include patient's health history, may require complaint-oriented physical examination and laboratory testing, Live Blood Cell Analysis, Arterial Stiffness Assessment, Bio-Impedance Analysis, Initiation of treatment plan</i>	Second Visit \$115
	Subsequent Visits \$95
Subsequent Consultations (typically up to 30 minutes) <i>Continuation and monitoring of treatment plan and health concerns.</i>	
Children (12 years of age and under)	
Initial Consultation (up to 60 minutes)	Initial Consultation \$175
2 nd Visit (30 minutes) <i>The first two visits include patient's health history, may require complaint-oriented physical examination and laboratory testing, Live Blood Cell Analysis, Initiation of treatment plan.</i>	Second Visit \$110
	Subsequent Visits \$90
Subsequent Consultations (typically up to 30 minutes) <i>Continuation and monitoring of treatment plan and health concerns.</i>	
Acute Consultations (Adult & Children)	
Acute Consultations for conditions of sudden onset <i>Fever, cold, influenza, headaches</i>	15mins \$65

Telephone Consultations*:

Clarification of treatment plan	\$0
Up to 15 minute phone consults	\$65

* Please note that telephone consultations are generally intended for follow-up consultation and clarification of treatment protocols. Telephone consults are offered to new patients only after an initial visit has been conducted and a treatment plan has been initiated.

I, (print name) _____, **DECLARE that I have read the above information and I agree to the above office policies.**

Signature of Patient (or Guardian): _____ Date: _____

Naturopathic Doctor: _____