FEE SCHEDULE

HealthSource
INTEGRATIVE MEDICAL CENTRE

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 <u>24 hours notice</u> if you intend to cancel an appointment.** If you must miss a treatment without proper notice, <u>you will be required to pay the full fee for the missed appointment</u>, except in the case of inclement weather or a true emergency.

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Initials

In-office, phone or video telemedicine appointments:

<u>Adult Consultation</u>		
Initial Consultation (up to 60 minutes)	Initial Consultation	$225
2nd Visit (up to 30 minutes) *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*	Second Visit	$125
	Subsequent Visits	$105
Subsequent Consultations up to 30 minutes) *Continuation and monitoring of treatment plan and health concerns.*		
<u>Children</u> (12 years of age and under)		
Initial Consultation (up to 60 minutes)	Initial Consultation	$200
2nd Visit (up to 30 minutes) *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.*	Second Visit	$115
	Subsequent Visits	$100
Subsequent Consultations (up to 30 minutes) *Continuation and monitoring of treatment plan and health concerns.*		
<u>Acute Consultations</u> (Adult & Children) *Acute Consultations are generally intended for clarification of treatment protocols or conditions of sudden onset. Acute consultations are offered to patients only after an initial visit has been conducted and a treatment plan has been initiated.*	15mins	$75

***If telephone or video consultations are the method of choice for the initial consultation. Payment will be required beforehand. Reception will call the individual to collect payment approximately 15 minutes before the scheduled appointment time.

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: _____