

MARIO ROXAS, ND  
Naturopathic Physician

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## FINANCIAL AGREEMENT

**Welcome to my office. Please familiarize yourself with the financial policy of my office by reading the following information about how your medical bills will be handled.**

### **OFFICE POLICY AND PAYMENT RESPONSIBILITY**

As the patient you are responsible for the total charges incurred for each visit. Currently, I only accept cash and checks. **There will be a charge of \$20 for each returned check.**

**There is a \$25.00 charge to you for missed appointments with no notification.**

In the event of non-payment you, the patient, shall bear the cost of collection and/or court costs and reasonable legal fees, should this be required. **Accounts past due will be assessed a 2% per month service charge.**

### **BILLING YOUR INSURANCE CARRIER**

Please check with your insurance company in advance to determine whether they offer coverage for naturopathic medicine. **You are responsible to bill your own insurance.** I can provide you with a signed service summary with all the necessary information for you to send directly to your insurance company for reimbursement. **Payments are due at the time of service.**

### **AGREEMENT TO PAYMENT POLICY**

By signing below, I understand that full payment for all services and products I receive from this clinic and its practitioners is required at the time of service. Further, I understand that this clinic may provide me with a bill that I may submit to my insurance carrier, if I so request, and that this clinic cannot be held responsible for either the amount of reimbursement I receive, nor any delay between the time of submission and the time of any reimbursement.

X

patient/guardian signature

date