

CONSENT AND PAYMENT POLICY

I, _____, (client), consent to receive naturopathic care and recommendations from Katrina Bogdon, ND of Our Healing Roots, LLC. I understand that I will not be receiving diagnostic information from my Naturopathic Doctor (ND). Dr. Katrina Bogdon is licensed as a naturopathic physician in the state of Washington and she received her four years of post-graduate naturopathic medical education and two years of residency through CMNE approved programs.

I understand that the state of Missouri does not license NDs and that Dr. Katrina Bogdon is not a Medical Doctor (MD) nor Osteopathic Doctor (DO).

I also understand that I will not be receiving any medical treatment or prescriptions from Dr. Katrina Bogdon.

____ (initial) I understand that Dr. Katrina Bogdon does not carry medical malpractice insurance and is not required to by law.

I understand that if Katrina Bogdon, ND determines that I am in urgent need of medical evaluation, she will refer me to my primary care physician, an urgent care or the emergency room. I understand that I must consult with my licensed medical provider to obtain medical evaluation, medical diagnosis, and medical treatment. If you need emergency medical attention, call 911 or go to the nearest ER.

SPECIAL INFORMATION FOR CANCER PATIENTS

If diagnosed with cancer, I understand that Katrina Bogdon, ND does not provide recommendations unless I am under the care and treatment of an oncologist. The care provided by Our Healing Roots, LLC, is not a substitute for oncology care but may be used integratively alongside prescribed oncology care.

PAYMENT AND FEES

Our Healing Roots, LLC, accepts payment via cash, check, credit card, and debit card. Payment is due at the time that services are provided. Failure to make payment at the time of service will result in a requirement to prepay all future visits with cash only. Future consults will not occur until outstanding balances are paid.

Initial client visits are priced at \$180.00 for a 90-minute visit. Follow up naturopathic consultations in Springfield are priced at \$90.00 for up to 45 minutes. Follow up naturopathic consultations in Seymour are priced at \$80.00 for up to 45 minutes. Shorter appointments are

available by phone during our Seymour office hours. They are pro-rated \$27 per 15 minutes (which includes the time spent reviewing your chart and looking up information).

If Katrina initiates contact with you to ask about your progress with her last recommendations, to let you know labs arrived, or to provide a reminder, there is no cost. If you bring up additional questions outside these topics they will be billable. If you call or send an electronic message with a question that directly relates to scheduling, billing, to report an adverse reaction to something Katrina Bogdon, ND recommended, or to ask for clarity regarding the recommendations made at your most recent visit, there is no additional cost. All other questions and concerns by telephone and electronic message will be billed and prorated per minute at a rate of \$27 per 15 minutes. Please see the Electronic Communication and Phone Policy for more details.

COLLECTION OF FEES

Any unpaid balance due and owing can be collected on by utilizing the services of a collection agency of Dr. Bogdon's choice and/or filing a lawsuit in the court of appropriate jurisdiction. All unpaid balances will be collected at an interest rate of 9% and Patient is responsible for any court costs, fees, and attorneys fees incurred in collecting said balance.

PRIVACY POLICY

For the privacy of your health information, text messages are blocked from the business phone.

I understand that the information I share with Our Healing Roots, LLC, will be kept confidential as described in the Notice of Privacy Practices. I understand that the Notice of Privacy practices is available for me to view upon request, in the office, and on this company's website.

APPOINTMENTS/CANCELLATION

Your appointment time is reserved for you. Should you need to reschedule, please call at least 24 hours before your appointment to avoid a \$30 cancellation fee.

Signing my name below attests that I have read the foregoing and that I to my understand the information above. I agree to these terms and acknowledge that this document is a binding contract for service.

Signature: _____ Date: _____

Dr. Katrina Bogdon, ND: _____ Date: _____