

HEALTH ALTERNATIVES, LLC
1015 4TH AVE WEST SUITE A/B
OLYMPIA, WA 98502
FINANCIAL POLICY FORM

Hours of Operation: By appointment only.

Contact Information: Phone – (360) 586-0117, Fax – (253) 276-0084, Email – clinic@cwis.org
Snail Mail – 1001 Cooper Pt. Rd., Suite 140, PMB 214, Olympia, WA 98502

Booking Appointments: A 50% deposit is required upon booking your initial appointment. To book a clinic or phone appointment, please call the Clinic's front desk at (360) 586-0117. The Clinic will try to schedule the client at their requested time. A client can also set up a regularly scheduled appointments each week for their convenience.

Appointment Costs: The initial appointment is \$150/hr, and subsequent appointments are \$120/hr. At the end of your first appointment an Estimate Cost Sheet will explain additional costs of testing and treatments. We do not bill. Payment is required at the time services are rendered.

Cancellation Policy: Scheduled appointments must be cancelled at least 24 hours prior to appointments. Missed appointments or appointments not cancelled 24 hours prior to the scheduled date and time will be charged 50% of the appointment price. If arrival for a scheduled appointment is late, the appointment will still end at the originally scheduled time.

Payment Options: Payment in the form of Visa, MasterCard, American Express, Personal Check and Cash are accepted. For your convenience, we can set up automatic payment by credit card. This option allows us to automatically charge your credit card for any treatment or product.

Insurance: We do not accept insurance, but we would be happy to provide you with receipts for submission. Please inquire for further information.

Staff: *Dr. Leslie Korn, Ph.D., M.A., MPH, NCB*
Founder and Director of Health Alternatives, LLC, lekorn@cwis.org

Contract for Care: I promise to participate fully as a member of my health care team. I will make sound choices regarding my treatment plan based on the information provided by my manual therapist or other members of my health care team. I agree to participate in the self-care program we select. I promise to inform my practitioner any time I feel my well- being is threatened or compromised. I expect my therapist to provide safe and effective treatment.

I _____ have read and fully understand the policies and contract above for Health Alternatives, LLC and have been given the opportunity to ask questions clarifying its contents. I understand that I am financially responsible for all charges and agree to pay for services. I understand the potential benefits and possible risks of the procedures offered by Health Alternatives, LLC. With this knowledge, I voluntarily consent to the policies and procedures offered by Health Alternatives, LLC, realizing that no guarantees have been given to me regarding cure or improvement of my condition(s) and release all staff of Health Alternatives, LLC from any and all liability which may occur in connection with any treatments/services provided. I understand that I am free to withdraw my consent and to discontinue participation at any time.

Client Signature

Date

Parent/Guardian (if minor)

Date