

Disclosure of Clinic Policies

Appointments:

Dr. Chapman is available for appointments from 9 am to 5 pm on Tuesdays, Thursdays and Fridays. To schedule an appointment, call 503-665-0460. If a cancellation is necessary, please give a 24 hour notice of this cancellation.

Fees:

Initial visit: \$120.00- \$250.00 depending on time and complexity.

This visit involves an extensive history, physical exam, diagnostic testing and initial treatment plan.

Return visits: \$50.00-180.00 depending on time and complexity

This visit involves an interpretation of diagnostic test results and a specific and targeted treatment plan based on those results.

Food sensitivity testing: \$125.00 for a comprehensive 100-food panel and dietary counseling.

Phone or email consultations: Any consult taking longer than 10 minutes will be billed as a return office visit.

Returned checks: \$35.00 service fee for all returned checks

No call/ No show: \$45.00 fee for missed appointment without cancellation

Payment:

Dr. Chapman bills select insurance plans that reimburse for naturopathic medicine at a reasonable and customary rate. Please contact your insurance plan about your individual alternative care benefit. You will be responsible for the remainder of fees that your insurance does not cover.

If your plan does not contract with Dr. Chapman, then you will be provided the necessary forms to submit for independent reimbursement.

If your plan does not cover Naturopathic medicine or does not cover Dr. Chapman as a provider, then payment will be due in full at the time of service.

Leigh Ann Chapman, ND
Integrative Family Medicine

Patient Information Form

Completion of this information in its entirety is required at the time of visit.

Name _____ Social Security # _____

Email Address: _____ Birth Date: _____

Home Address: _____

City _____ State _____ Zip _____

Home Phone#: _____

Employer: _____ Occupation: _____

Employer Address: _____

Work Phone #: _____

Spouse's name: _____

Spouse's Employer: _____ Occupation: _____

Referral Source: _____

In case of an Emergency...

Relative to contact: _____ Phone#: _____

Other person to contact (not relative): _____ Phone#: _____

I acknowledge that I am financially responsible for all charges at the time of service. If it becomes necessary to effect collections of any amount owed on this or subsequent visits, the undersigned agrees to pay for all costs and expenses, including reasonable attorney fees. I hereby authorize the doctor to release information to secure payment of benefits.

Signature: _____ Date: _____

If someone other than the PATIENT is responsible for payment, complete the following:

Name of responsible party: _____

Address: _____

Relationship to patient: _____ Social security #: _____

Home Phone #: _____ Work Phone #: _____

Leigh Ann Chapman, ND
Integrative Family Medicine

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Consent to Treatment of A Minor

I, being the parent/ guardian of _____, a minor, the
age of _____ do hereby consent, authorize and request Dr. Leigh Ann Chapman to
administer such treatment deemed advisable, necessary or requested on the above minor.

Signed _____ Date _____
(Parent or Guardian)