Corina B. Going, ND
Naturopathic Physician ◈ Classical Homeopath
309 South G Street, Suite 4 Tacoma, Washington 98405
(253) 341-9410 fax: (253) 442-6144

FINANCIAL POLICY

INSURANCE

Thank you for choosing naturopathic care as part of your health care! **Please be aware that you are responsible to know your own insurance coverage** **Dr. Going does not accept patients with Tricare or Molina.** Please check with your insurance company before your visit to find out your benefits for naturopathic care, including the amount covered, the number of visits covered, and whether Dr. Going is a covered provider with your plan. Please be aware of any copay and deductible for which you are responsible. Dr. Going uses an independent billing service to send claims to medical insurance carriers and invoices to patients for balances owed. Payment for invoices reflecting your financial responsibility is due on receipt of the invoice. Your copay and payment for any supplements or remedies that Dr. Going may prescribe are due at the time of the appointment. If we are not billing insurance, full payment is due at the time of service. You are responsible for all charges that are not covered by your insurance.

Accounts not paid in full within 30 days are considered past due and will be subject to a $15 rebilling charge. If you choose to terminate care with Dr. Going you are stil responsible for invoices for services and supplements received.

CANCELLATIONS

We understand that circumstances do occur making it difficult to keep appointments, however, we ask you to notify us at least 48 hours in advance if you cannot keep an appointment. We charge a missed appointment or a cancellation less than 48 hours in advance at half the regular visit rate and we charge the full amount for a no-show or a cancellation less than 24 hours in advance. Thank you for your understanding and patience with our decision to take credit card numbers to hold a new patient appointment. New patient no-shows and late cancellations were creating an unfair situation for other new patients who were waiting up to 2 months for an appointment. Unavoidable emergencies are considered exceptions to this policy.

PAGER, PHONE, TEXT and EMAIL CONSULTS

When the clinic is closed from Friday through Sunday and after 6:00 pm, we are available for urgent needs only; please leave a message on Dr. Going’s phone. For a medical emergency, please call 911. We charge $25 per after-hours phone call.

Any phone consults done during regular office hours that are not covered by insurance will be charged at a minimum fee of $30 for the first 10 minutes and an additional $10 per 5 minutes thereafter. Phone calls for clarification of instructions given at your visit or for brief questions are not charged.

Emailing is reserved for questions that can be answered by one email and are for clarification of a treatment plan or to check in with Dr. Going if she has requested that you do so. These will not be charged. Any email questions that require multiple emails

or that are for a new condition will either be charged at the phone rate above or you may be asked to come in for an office visit.

PHARMACY
You are responsible for payment at the time of visit of any pharmacy items prescribed. For any refills on pharmacy items prescribed by Dr. Going, please call the office 24 hours in advance. A Square invoice can be emailed to you when you place your order or you can leave a check at the time of pick-up.

FORMS REQUESTS

Filling out HSA reimbursement forms, FMLA forms or other documentation requested by the patient will be charged at $25-$50 depending on items entered or time spent by Dr. Going.

RETURNED CHECK FEE
A fee of $25 will be charged for all returned checks.

Please read the following before signing:

I authorize the release of any medical information necessary to process my insurance claims and I authorize payment of medical benefits to the supplier of services, Dr. Going, described on claims submitted on my behalf.

I agree to the financial policies of Dr. Corina Going. In the case of default of payment, I agree to pay any legal interest on the balance due, collection of costs and reasonable attorney fees incurred to effect collection on this account.

- ☐ Checking this box serves as my signature and indicates agreeement with the above policies.

Person Completing Form: ____________________________ Date: ________________