Financial Agreement Letter

Date: [Date]

Patient Name: [Patient Name]

Patient ID/DOB: [ID or Date of Birth]

Dear [Patient Name],

Thank you for choosing [Clinic Name] for your integrative healthcare. To ensure a clear understanding of our financial policies, please review and sign this agreement.

1. Payment for Services

Payment is due in full at the time of service. We accept cash, credit cards, and [Other Payment Methods].

2. Integrative Services and Insurance

Many integrative therapies (such as nutrition counseling, supplements, or specialized testing) may not be covered by standard insurance providers. It is your responsibility to verify coverage with your provider. We are a [In-Network/Out-of-Network] provider.

3. Cancellation Policy

Cancellations made less than [24/48] hours before an appointment will result in a fee of $[Amount].

4. Supplements and Lab Kits

Payments for nutritional supplements and specialized lab kits are non-refundable once dispensed or ordered.

5. Outstanding Balances

Accounts unpaid for more than [30/60] days may be subject to a late fee of [Percentage/Amount].

By signing below, I acknowledge that I have read, understood, and agreed to the terms of this Financial Agreement.

Patient/Guardian Signature: _____

Date: _____

Clinic Representative: [Name/Title]

Clinic Name: [Clinic Name]

Phone: [Phone Number]