



Dr. Lou Walters
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Payment Agreement

INSURANCE

The Source Wellness Center, PLLC does take health insurance. However, not all insurance plans cover naturopathic medical care. It is your responsibility to make sure your insurance policy covers the treatment you are receiving. Our staff will assist you in determining your benefits if needed. If any portion of treatment is not covered by your policy or you have not yet met your deductible, you are responsible for payment. You are responsible for in-house medicinal and other supplies purchased in the office.

PAYMENT

Full payment is due at time of service for office visits, co-pays, and supplements. We accept cash, check, credit, and debit cards. Checks denied for lack of funds will be assessed and you will be responsible for any fees charged.

APPOINTMENT CANCELLATION POLICY:

Appointments cancelled with less than 24 hours notice or missed appointments will result in a \$50 fee. Three such events will result in the termination of the doctor/patient relationship.

PHONE CALLS/EMAIL

There is no fee for brief questions over the phone or by email. Phone and Skype consultations can be arranged if you cannot make it to the office. These are the same price as our office visits.

I have read and understand that I am financially responsible for, and agree to pay for, all charges and services at The Source Wellness Center, PLLC. I give permission for the release of information to my insurance company to process a claim. I am responsible to notify the office of any insurance carrier or policy changes if they arise.

Signature: _____ Date: _____
 Social Security #: _____ Date of Birth: _____

HEALTH INSURANCE INFORMATION:

Company: _____ Insured's Name: _____
 Address: _____ Insured's DOB: _____
 Insured's SS#: _____ Group #: _____
 Policy #: _____ Certificate #: _____
 Have you filed on the condition in the last year? YES NO

CO-INSURANCE INFORMATION

Company: _____ Insured's Name: _____
 Address: _____ Insured's DOB: _____
 Insured's SS#: _____ Group #: _____
 Policy #: _____ Certificate #: _____

Relation to Insured: Self Spouse Child Other