NOURISH NATURAL HEALTH CLINIC

Shannon R. May, N.D., L.Ac
Naturopathic Doctor and Acupuncturist

NOURISH NATURAL HEALTH CLINIC
FEE SCHEDULE

Payment is required at the time of service, unless previous arrangements have been made. We accept cash, checks, VISA, or Mastercard for payment.

New Adult Patient Office Visit	**$200**
(approximately 1 ½ hours)	
New Pediatric Patient Visit	**$150**
(approximately 1 hour)	
Routine Return Visit	**$60-90**
(approximately 60 min)	$90
(approximately 30 min)	$60
New Patient Acute Visit	**$120**
(approximately 30 - 45 min)	
Return Patient Acute Visit	**$60**
(approximately 15 – 30 min)	
Phone/Skype Consults	**$60-90**
(Same as Routine Return Visits)	

**Phone calls and email messages regarding questions about your current treatment plan, and taking less than 10 minutes of time, are not charged.*

**Any laboratory fees, imaging fees or natural supplement items that may be recommended are not included in the office visit fee.*

Insurance Reimbursement*:*

Currently, insurance companies and HMO's in Minnesota do not cover naturopathic services. Flex Spending programs may allow for naturopathic health care deductions. Check with your plan administrators. We recommend that everyone ask their insurance providers to allow coverage for natural healthcare expenses.
However, insurance billing for certain lab work is possible with some insurance companies.

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Cancellation Policy:

If you need to change or cancel your appointment, please give us at least 24 hours notice. Appointments that are either missed or cancelled with less than 24 hours notice (excluding emergencies) will be charged a $75 (New Patient Visits) or $40 (Return Visits) fee.

I have reviewed the above fees and understand that I am responsible for payment at the time of service, unless previously arranged by Dr. May. I also understand that I will be billed for phone or Skype consultations and e-mail correspondence, except those regarding questions about prescribed treatments and conditions already being treated, and lasting less than 10 minutes of time.

In addition, I understand that lab work may or may not be covered by my insurance plan and that I am responsible for payment of lab work ordered if my insurance company does not cover it. I also understand that I will be charged $35 for appointments cancelled without 24 hours notice, except in cases of emergency.

Signed: ______________________ Date: ____________________