FEE SCHEDULE

HealthSource
INTEGRATIVE MEDICAL CENTRE

For the office to run efficiently and serve you best, we ask that you understand that your appointment is set aside and personalized for you. As such, **we require <u>24 hours notice</u> if you intend to cancel an appointment.** If you must miss a treatment without proper notice, <u>you will be required to pay the full fee for the missed appointment</u>, except in the case of inclement weather or a true emergency.

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Initials

Office Visits:

<u>Adult Consultation</u>		
Initial Consultation (up to 60 minutes)	Initial Consultation	$165
2nd Visit (30 minutes) *The first two visits include patient's health history, may require complaint-oriented physical examination and laboratory testing, Live Blood Cell Analysis, Arterial Stiffness Assessment, Bio-Impedance Analysis, Initiation of treatment plan*	Second Visit	$100
	Subsequent Visits	$80
Subsequent Consultations (typically up to 30 minutes) *Continuation and monitoring of treatment plan and health concerns.*		
<u>Children</u> (12 years of age and under)		
Initial Consultation (up to 60 minutes)	Initial Consultation	$150
2nd Visit (30 minutes) *The first two visits include patient's health history, may require complaint-oriented physical examination and laboratory testing, Live Blood Cell Analysis, Initiation of treatment plan.*	Second Visit	$90
	Subsequent Visits	$75
Subsequent Consultations (typically up to 30 minutes) *Continuation and monitoring of treatment plan and health concerns.*		
<u>Acute Consultations</u> (Adult & Children)		
Acute Consultations for conditions of sudden onset *Fever, cold, influenza, headaches*	15mins	$50

Telephone Consultations*:

Clarification of treatment plan	$0
Up to 15 minute phone consults	$50

** Please note that telephone consultations are generally intended for follow-up consultation and clarification of treatment protocols. Telephone consults are offered to new patients only after an initial visit has been conducted and a treatment plan has been initiated.*

I, (print name) _____, DECLARE that I have read the above information and I agree to the above office policies.

Signature of Patient (or Guardian): _____ Date: _____

Naturopathic Doctor: _____