Advance Biomedical
Treatment Center

Eileen C. Comia, M.D.
35 Jolley Drive Suite 102
Bloomfield CT 06002
Tel (860)242-2200
Fax (860)242-2212
info@advbiomedtx.com

IV (INTRAVENOUS) THERAPY FINANCIAL POLICY AGREEMENT

Thank you for your interest in scheduling an appointment. The following is our Financial Policy that you must read and understand prior to your consultation.

PHYSICIAN CONSULTATION

All NEW patients must consult with the practitioner. The consultation includes a review of your medical history and determination of your medical eligibility for the IV treatment being requested. The consultation normally runs about an hour but may extend depending on the complexity of a patient's problem. The Consultation Fee is $125.00 per 15 minutes.

To schedule an appointment, please complete the following:

1. Patient Registration Form
2. **Non-refundable** $125.00 Scheduling Fee – applied towards the Physician Consultation Fee
3. IV Therapy Financial Policy Agreement

Cancellation/Rescheduling Policy: All cancellations/rescheduling must be done at least 24 hours BEFORE the appointment. If done less than 24 hours to the appointment, a new $125.00 Scheduling Fee will be required. When calling the office and you reach our voicemail, leave your name and telephone number. We will call you back to confirm the message. IF YOU DO NOT GET A RETURN CALL, WE DID NOT GET YOUR MESSAGE.

Missed/No Show Appointment Policy: The Scheduling Fee will be forfeited if a patient misses an appointment. It cannot be applied towards a future appointment.

IV THERAPY

Due to prescription requirements and increased costs for IV nutrients, FULL payment for the therapy is DUE AT THE TIME OF APPOINTMENT SCHEDULING. The IV Therapy Fee is **FINAL AND NON-REFUNDABLE**. The fee varies depending on the medical condition being treated. Please contact the office for an updated rate.

You agree to allow our office to charge your credit card (or alternate payment method) for the cost of the service you are scheduled to receive. You acknowledge and accept full responsibility to ensure that you pay Advance Biomedical Treatment Center any fees due at the time your appointment is scheduled. You are responsible for making sure that your payment information remains accurate and up-to-date.

Cancellation Policy/Rescheduling: All cancellations/rescheduling must be done at least 24 hours BEFORE the appointment. You forfeit the entire cost of the service if you cancel/reschedule less than 24 hours to the appointment AND/OR you cancel and not reschedule. (Special consideration will be given to true emergencies. A written proof is required for documentation and consideration.)

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Missed/No Show Appointment Policy: The entire cost for the service you've been scheduled to receive is forfeited if you miss an appointment.

Advance Biomedical Treatment Center does not participate with any insurance company. We do not file for insurance. We do not provide diagnostic codes. You are responsible for payment in full.

Thank you for taking the time to understand our Financial Policy. We look forward to meeting you.

I have read, fully understand, and agree to abide by the IV Therapy Financial Policy Agreement.

_____ _____
Printed Name and Signature of Patient Date

_____ _____
Printed Name and Signature of Guardian, if minor Date

Please indicate your preferred method of payment:

_____ Cash

_____ Visa / MasterCard:

Name as it appears on the card: _____

Signature of cardholder: _____

Card no.: _____ 3-Digit no.: _____

Expiration Date: _____ Billing Zip Code: _____