Rhythm of Health, Inc.
Because great health is a choice

8160 Coller Way, Suite A
Woodbury, MN 55125
(651) 208-1084
www.rhythmofhealth.com

Office Policies and Fees

All patients should note the following fees that are customarily charged and for which payment is expected at the time of service unless other arrangements have been agreed upon in advance. We accept checks, cash, debit cards, Visa, MasterCard, and Discover.

Office visits
Initial office visits are scheduled for 120 minutes, follow-up office visits are scheduled for 60 minutes, and telephone consultations are scheduled for 30 minutes. My standard office rate is $150/hour. Appointment fees vary based upon the amount of my time spent providing care. But, on average, you can expect:

Initial visit (90 – 120 minutes)	$225 – 300
Follow up visit (30 – 50 minutes)	$75 – 125
Telephone consultations (15 – 30 minutes)	$38 – 75

Late cancellation fees
It should be understood and agreed that all patients are expected to give 24 hours notice of cancellation of an appointment. Any late cancellation, or failure to keep an appointment, will incur a $45 charge. These charges are due immediately upon receipt of an invoice, or at the time of the next appointment, whichever comes first.

Laboratory fees
It should be understood and agreed that laboratory tests may be recommended, and that you have the right to decline to have such laboratory tests completed. However, should you choose to complete the recommended tests, you are responsible for all fees associated with these tests. These fees, due at the time the lab kits dispensed to the patient, include:

- Fees for laboratory tests including blood, urine, saliva, and stool tests
- Venipuncture (blood collection) fees – $15 per blood draw
- Lab handling fees – $15 when applicable

Herbs, nutritional supplements, homeopathic medicines, or other medical supplies
Recommended supplements may be purchased at Tailor Made Nutrition, not through Rhythm of Health, Inc.

Returned checks
There is a $30 fee for any returned checks.

I have read and understand the above-stated policies, and fee schedules of Rhythm of Health, Inc., and will comply with them in all respects.

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Signature (patient or authorized party)	Print Name	Date