nutrition sense
NUTRITIONAL COUNSELING

FINANCIAL POLICY

Please understand that the payment of your bill is considered part of your treatment. The following statement explains our financial policy. Please read the policy, sign and return it to us prior to your treatment.

I, _____, understand I am responsible for payment of any charges and agree to pay Nutrition Sense, LLC the regular charges for all nutrition related services rendered to me. I agree to pay those charges that are not covered by or paid by my insurance provider as soon as I receive the bill. If I do not pay my bill, I agree to pay Nutrition Sense. LLC any collection costs it may incur.

If your insurance provider does not cover nutrition visits, payment is due at the time of service. We accept cash, credit and checks.

Returned Checks
For checks returned to us as unpaid by your bank, you will be charged a $35 fee. Any legal feed that Nutrition Sense, LLC incurs to secure past due balances will be added to your account.

Missed Appointments
Please provide at least 24 hours notice of cancellation as a courtesy. Our policy is to charge $75 for missed appointments without appropriate notice. Please help us to serve you better by keeping scheduled appointments.

Credit Card to keep on file for cancellation charges:

Name on Card _____

Card Number _____

Expiration _____ Billing Zip Code _____

I understand that I am financially responsible for the charges that I incur during my treatment under the care of Nutrition Sense LLC. This includes all nutrition therapies, supplements, office visits, laboratory and imaging charges.

I have read and agree to this financial policy.

Signature of Patient _____ Date _____

Name of Guardian _____ Relationship _____

Signature of Guardian _____Date _____