**Nutrition Solutions**
12911 120th Avenue NE • Suite B50 • Kirkland, WA 98034 • (425) 825-8088

**Payment and Policy Information for Debie McSperitt RDN, CD**

Please read the following information carefully and sign at the bottom of the page prior to treatment. If you have any questions, ask for clarification.

**Insurance Policy**

Although my insurance will be billed for reimbursement, there is no guarantee of insurance coverage. It is my responsibility to know my plan benefits, including co-payment amounts, deductibles, and what are covered and non-covered services. I give permission for the release of information requested by my insurance provider to assist in processing my insurance claim. I understand that the insurance co-payment is due at the time of service and that I am financially responsible for paying any portion of the bill that my insurance does not cover for myself or my dependents. I will be held responsible for non-payment by my insurance plan. If my account is unpaid by the insurance company 120 days after the claim has been submitted, I will be billed for the balance due.

Insurance can only be billed for in-clinic appointments and does not cover telephone or e-mail consults, appointments outside of the clinic, or cancellation/no-show fees. I understand these fees are my responsibility.

**Payment Policy**

Without insurance coverage, I will be considered self-pay and my balance will be collected in full at the time of service.

Checks that are returned for non-sufficient funds will incur a fee of $35.00.

A late charge of $10.00 will be assessed for any unpaid balances that are over 30 days past due. An additional $10.00 will be added monthly until the balance due is paid in full. In case of default, I am responsible for full payment of the balance due, late charges, and any collection costs and legal fees incurred to collect on this account.

**Cancellation Policy**

If I am not able to keep an appointment, I must cancel with at least 24 hours notice to avoid a charge. There is a $35.00 fee for cancellations with less than 24 hours notice. Full fee will be charged if no notice is received.

**I agree to the payment policies.**

_____
Print Name

_____ _____
Sign Name Date