Taste Life Nutrition Therapy, LLC

Payment and Cancellation Agreement

- The dietitians at Taste Life Nutrition Therapy, LLC are currently accepting the following insurance panels: Cigna, Aetna, Health Choice, United Healthcare and Blue Cross Blue Shield. Prior to initial session your dietitian will check benefits with your insurance.
- If your insurance is not accepted, clients must pay for services up front, and will be provided a superbill at the end of each session to submit to their insurance for reimbursement. All clients are responsible for checking insurance benefits. A superbill does not guarantee reimbursement to cover services provided.
- I am responsible for any non-covered services, deductibles, co-payments or co-insurances, as determined by your insurance carrier.
- If my insurance policy changes, I am responsible for checking benefits for out-patient medical nutrition therapy services and providing new insurance information to Taste Life Nutrition Therapy, LLC.
- All appointment cancellations must be completed within 48 hours prior to scheduled session. Failure to cancel or if I no-show will result in a $50 fee (each client will have a 1 time forgiveness). Repeated cancellations, rescheduling, or no-shows will result in being charged for a full session.
- Any cancelled or no-showed appointments can be rescheduled for any time still available.
- Appointments will start on time. If I am late, my session will last only as long as scheduled, but not beyond that. I will still pay for my full appointment.
- No refunds will be issued for any completed service.
- There will be a $30.00 charge for any returned checks.
- Unpaid balances in excess of 30 days will be charged a 1.5% per month.
- I understand I am required to pay for all sessions up front if my insurance is not accepted. If any balance remains, I must pay it within 30 days of services rendered. If I do not pay the balance within 30 days, I authorize Taste Life Nutrition Therapy, LLC to charge my credit card provided on file for the remaining balance.
- Taste Life Nutrition Therapy, LLC requires I provide my credit card information for filing purposes (this will be kept in a secure place).
- I understand that I am responsible for deductibles and non-covered services at time of service rendered.
- I understand I am responsible for any balance unpaid by insurance agreement (example: insurance pays 80%, client pays 20%).
- I understand that this document will be required to be updated each year.

Type of Credit Card: _____ Card Number:_____

Exp Date (MM/YY): _____ CV Code (on back): _____ Billing Zip Code: _____

By signing, I agree to the cancellation and payment policies of Taste Life Nutrition Therapy, LLC as listed above. I understand that they are in the best interest of the provider and me. I also understand that any recommendation and/or intervention provided by the dietitians at Taste Life Nutrition Therapy, LLC are not be used in place of medical advice provided by a physician.

_____ _____

Signature **Date**

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Printed Name