Monadnock
Nutrition Services

Monadnock Nutrition Services Acknowledgement of Financial Responsibility

I understand and agree that it is my responsibility to know the benefits of my health insurance plan, specifically coverage regarding nutritional counseling.

I understand and agree that it is my responsibility to know if my insurance requires a referral from my primary care physician and that it is up to me to obtain that referral. I understand that without this referral, my insurance will not pay for any services and that I will be financially responsible for all services rendered.

I agree to allow Monadnock Nutrition Services to keep an active credit card on file to be charged for any of the below insurance benefit limitations:

- Any deductible, copayment, co-insurance, out-of-network, usual and customary limit, prior authorization requirements or any other type of benefit limitation for the services I receive.
- The complete amount due if my health plan determines a service to be "not payable."
- If my health plan processes my claim incorrectly ***OR*** covers less than 100% of the "allowed amount" (varies based on your specific plan).

I understand and agree that if I need to cancel or reschedule any appointment, I will give Monadnock Nutrition Services as much advanced notice as possible. I understand that one cancellation within 24 business hours of an appointment for any reason will be acceptable each year. During that same year, any second or repeat cancellation with less than 24 hours notice will be charged $50.00 via the credit card kept on file. Furthermore, I understand and agree that insurance companies cannot be billed for "no-show" fees. Therefore, I authorize payment of $150.00 for any "no-show" visit via the credit card kept on file.

I understand and agree that any checks returned for non-payment will be charged a $25.00 returned check fee.

I understand and agree that any accounts more than 90 days past due will be sent to a collection agency.

Patient Written Acknowledgement of our HIPAA statement privacy policy notice: This office complies with state and federal privacy laws. A copy of our privacy practices is available upon request.

☐ Check here if you wish to receive a copy of our privacy statement.

My signature below acknowledges that I hereby accept financial responsibility for present and future nutrition counseling sessions with Monadnock Nutrition Services:

Please print client's name: _____

Signature of responsible party: _____

Date: _____