Patient Name: ____

DOB: ______________________________

Financial Policy

It is the responsibility of the patient/parent/guardian to contact their insurance company and verify benefits. **Idaho Nutrition** is in-network with most insurance plans, however due to the many networks that fall under various insurance companies, it is always important to ensure that **Idaho Nutrition** and/or your Registered Dietitian are in your network. In addition, we recommend determining benefit details related to nutrition services prior to your first appointment, **including whether your plan will cover Telehealth appointments as this is an available option for follow-up appointments.**

Idaho Nutrition is happy to submit an insurance claim on your behalf. However, **Idaho Nutrition** has **no control** over claim processing. A quote of benefits is never a guarantee of payment from an insurance company. The patient/parent/guardian is responsible for all claim determinations and balances due on patient account including but not limited to non-covered services, deductibles, copays, & coinsurance.

All account balances that remain delinquent after 90 days, with no response to payment requests, will be referred to a collection agency.

If **Idaho Nutrition** is not in-network with your plan or it has been determined that you do not have insurance benefits, we do offer discounts for those paying out-of-pocket. In this case, payment is expected at the time of service. A superbill can be provided upon request.

Idaho Nutrition accepts cash, checks, debit cards, credit cards and HSA cards. A $30 fee will be imposed on all returned checks.

Late Cancellation Policy

We are committed to you and have great respect for your time, and we ask that you extend that same commitment to **Idaho Nutrition as well as our other patients**. It is challenging to meet the scheduling needs of our patients with short notice cancellations or simply not showing up for a scheduled appointment.

Please communicate the need to cancel/reschedule in a timely manner via phone, voicemail, email, or text. You receive an appointment confirmation at the time of scheduling, as well as appointment reminders as your appointment approaches. Please make it a priority to add your appointment to your calendar.

Late Cancellation Agreement: *The patient/responsible party agrees to notify* ***Idaho Nutrition*** *a minimum of 24 hours in advance if unable to attend a scheduled appointment. There is a* ***$50*** *late cancellation fee for less than 24 hours advance notice. If the patient has pre-paid for a visit(s), fees will be deducted from their account accordingly.* **__________ *(initial)***

I acknowledge that I am financially responsible for the patient identified above. I have read, understand, and agree to Idaho Nutrition's financial and late cancellation policies as stated above. As the financially responsible party, I accept full responsibility for any expenses incurred.

Financially Responsible Party (print full name) ____

Relationship to patient (circle one): Self Parent Guardian Spouse

Signature: ____ **Date:** ________________________