MNC Nutrition

Philadelphia, PA

Statement of Patient Financial Responsibility

Patient Name: _____DOB: _____

***Please place your initials before each statement indicating that you have read and understand our policy**

_____This is a statement of our financial policy. You understand that you are obligated to ensure that our fees are paid in full. All appointments are considered "fee for service." Appointment fees are due at the time of service. We accept cash, check, or credit card (3% processing fee is added to all credit card charges).

_____MNC Nutrition, LLC is an in-network provider for some insurances. It is your responsibility to verify your coverage within your individual insurance plan. Not all plans cover nutrition services, and not all nutrition services are covered by insurance. We will bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill.

_____ If you are not covered under your health insurance, you may have "out of network" benefits that could cover a percentage of your appointment fees. Contact your insurance company directly to determine if your insurance company will reimburse you for the cost of appointments. Upon request, we will provide you with a receipt when a nutrition-related diagnosis code is provided. You can submit this receipt to your insurance company directly for reimbursement.

_____You agree that you will pay any deductible and co-payment or co-insurance as determined by your insurance plan. Those payments will be due at the time of service. Many insurance companies have additional requirements, or stipulations that may affect your coverage. You are responsible for any amounts not covered or payable by your insurance. If your insurance denies any part of your claim, you agree to be responsible to pay the full balance.

_____ **{for clients/patients purchasing out-of-pocket Nutrition Sessions}** Appointments are meant to be scheduled once per week, or bi-monthly. If you need to cancel or reschedule an appointment, we ask that you provide at least 48 hours' notice. A last-minute cancelation or a no-show appointment will be charged at the full fee.

ACKNOWLEDGEMENT:

I have read and understand the financial policy described above. I agree to pay, promptly and in full, any amounts due to the provider, including co-payments, deductibles, and amounts due for non-covered or services that are not payable by my insurance.

Patient Signature _____ Date _____

If minor, parent/legal guardian signature _____for
_____ (patient/client) Date _____