

Patient Name: (print) \_\_\_\_\_ Date: \_\_\_\_\_

## FINANCIAL AGREEMENT

### Financial Responsibility

I understand that in consideration of the services provided to the patient, I am directly and primarily responsible to pay the amount of all charges incurred for services provided by Kathy Whorley. I am responsible for any applicable deductible or co-payment prior to the provision of services. Kathy Whorley agrees to contact my insurance company to ascertain nutrition benefits and may file a claim for payment as required by contractual agreement. If the insurance company fails to pay Kathy Whorley in a timely manner for any reason, then I understand that I will be responsible for prompt payment of all amounts owed to Kathy Whorley. I understand that the cost of an initial office visit is \$150.00 and that the follow up visits are \$85.00. Should the amount be referred to a collection agency or attorney for collection, the undersigned shall pay all costs of collection, including a reasonable attorney's fee.

### Responsibility to Provide Proof of Insurance and Obtain Referral

I understand it is my responsibility to provide Kathy Whorley with a copy of my current insurance card and to obtain a referral from my Primary Care Physician for medically necessary nutrition assessment and intervention. If I do not have insurance, or my insurance does not include a provision for nutrition services, I may be considered a Private Pay (or Self Pay) patient and I am financially responsible for the total amount of services provided, in which case a cash discount may be applied.

### Additional Information

Kathy Whorley accepts payment in cash, check, or credit card. I understand additional charges are applied to my account for any returned checks used to pay on my account, for certified letters sent to me for collection on my account and collection agency fee. I understand that Kathy Whorley requires twenty four (24) hours' notice for cancellation of any appointment. I understand if I fail to notify Kathy Whorley within this time frame, I may be charged the full amount of an office visit.

### Assignment of Benefits

I hereby authorize and assign all payments and/or insurance benefits for nutrition services rendered to the patient, directly to Kathy Whorley. I hereby authorize Kathy Whorley to release medical information necessary to obtain payment. I understand that I am responsible for all charges not covered by my insurance plan. In the event I receive payment from my insurance carrier, I agree to endorse any payment due for services rendered to Kathy Whorley.

### *Signature*

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ; UNDERSTAND AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

Patient Signature: \_\_\_\_\_

Parent, Guardian or Legal Representative Signature: \_\_\_\_\_

Signature who reviewed intake forms: \_\_\_\_\_