Sheri K. Mar, MS, CN, Nutrition Counseling & Services / Eat Well, Be Fit!
P.O. Box 17468, Seattle, WA 98127
(206) 789-6440 Email: info@eatwellbefit.com

Payment Policy Agreement and Release of Information

Please read the following information carefully and sign the following page prior to treatment.

Insurance Policy

If insurance is billed for reimbursement, there is no guarantee of insurance coverage. It is my responsibility to know my plan benefits, including copayment amounts, deductibles, and what are covered and non-covered services. I give permission for the release of information requested by my insurance provider to assist in processing my insurance claim. I understand that the insurance co-payment is due at the time of service and that I am financially responsible for paying any portion of the bill that my insurance does not cover for myself or my dependents. I will be held responsible for non-payment by my insurance plan. If my account is unpaid by the insurance company 60 days after the claim has been submitted, I will be billed for the balance due. Insurance can only be billed for in office appointments and does not cover telephone or e-mail consults, appointments outside of the clinic, or cancellation/no-show fees. I understand these fees are my responsibility.

Payment Policy

Without insurance coverage, I will be considered self-pay and my balance will be collected in full at the time of service. Checks that are returned for non-sufficient funds will incur a fee of $35.00. A late charge of 10% will be assessed for any unpaid balances that are over 60 days due and each month thereafter until the balance is paid. I am responsible for full payment of the balance due, late charges, and any collection costs and legal fees incurred to collect on this account.

No refunds are allowed for paid or pre-paid services.

Purchased appointment packages will expire one year after date of initial payment whether or not all appointments have been utilized.

Cancellation Policy

If I am not able to keep an appointment, I must cancel with at least 48 hours notice to avoid a charge. There is a $35.00 fee for cancellations with less than 48 hours notice. Full fee will be charged if no notice is received.

I agree to these payment policies. Please fill-in and sign the attached page.

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Please Read Carefully and Sign

I (client name)_____

Address:_____

City/State/Zip_____

Phone: _____

- authorize Sheri K. Mar, MS, CN, Nutrition Counseling & Services to give, receive, or exchange information for medical and/or insurance purposes, and authorize Sheri K. Mar, MS, CN, Nutrition Counseling & Services to obtain any information from my primary healthcare providers concerning my health.
- authorize payment of medical benefits to Sheri K. Mar, MS, CN for services. This authorization may be withdrawn at any time by contacting Sheri K. Mar, MS, CN.
- understand that nutrition services rendered are my personal financial responsibility; if for any reason payment is denied or partially paid by my insurance provider, I agree to pay Sheri K. Mar, MS, CN for the services I have received.
- understand that I will be responsible for payment of appointments cancelled with less than **48 hours** notice.
- understand all accounts past the due date of 60 days will accrue interest at a rate of 10% per month until the balance and late fees are paid in full.

Client/Guardian Signature:_____

Date_____