SOUND DIETITIANS

PO BOX 5115
LYNNWOOD, WA 98046

PHONE: 425-409-3544
FAX: 425-354-3544

Policies

Financial Agreement

It is the patient's responsibility to check insurance benefits and coverage. You will be responsible for any non-covered services, deductibles, co-payments or co-insurances, as determined by your insurance carrier. Accounts unpaid by the insurance carrier greater than 90 days will be billed to the patient.

Out-of-pocket payments can be made via credit/debit card, cash or check and are due on the date of your appointment. Credit/debit card payments can be made directly with your Registered Dietitian. Please make checks payable to Sound Dietitians. There is a $35 fee for all returned checks.

Cancellation Policy

We request 48 hours notice for cancellation or rescheduling of appointments. This allows us to offer the time to another client.

Appointments that are missed or cancelled within 24 hours will be charged a $30.00 fee.

This fee will be automatically charged to the credit card you have on file with us and we will send you a receipt for your records. Please note that insurance companies will not cover missed appointment charges and, thus, this expense is not reimbursable to you.

I, _____(please print your name), agree to the above financial and cancellation policies. In the case of default payment, I am responsible for full payment of the balance, interest accrued, and any collection costs and legal fees incurred to collect on this account. I understand the scope and limitations of my insurance coverage and agree to pay all fees not covered by my insurance plan. I, the undersigned, have read, understand, and accept the information and conditions specified in this agreement.

_____

Signature of Patient or Responsible Party Date

Printed Patient Name: _____ DOB: _____