SOUND DIETITIANS

PO BOX 5115
LYNNWOOD, WA 98046

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

Policies 2020

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.

Please call our office if you would like to make a payment with a credit/debit card. Please make checks payable to Sound Dietitians. There is a $35 fee for all returned checks.

Cancellation Policy

Appointments that are missed or cancelled within 48 hours will be charged a $50.00 fee.

This fee will automatically be charged to the credit card you have on file with us. 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: _____