Financial and Cancellation Policy

Financial Policy:
I clearly understand and agree that I am personally responsible for payment of all services rendered to me by Cascade Nutrition Consulting. I agree to allow Cascade Nutrition Consulting to bill my insurance company as a courtesy, permit the release of records necessary to process my claims and authorize payments to be made directly to Cascade Nutrition Consulting for services rendered.

I understand that benefits are subject to insurance guidelines, policies, procedures and my eligibility at the time of service. Information received is not a guarantee of coverage and I may be responsible for additional charges.

- Cascade Nutrition Consulting will do our best to inform you of your financial responsibility prior to your appointment.

I further understand that co-payments, co-insurance and unmet deductibles (if applicable) are due at the time of service and that I will subsequently be billed for all charges not covered by my insurance company.

- Payment in full is due at time of service for clients without insurance coverage for Medical Nutrition Therapy.

Cancellation Policy:
Cascade Nutrition Consulting retains the right to charge patients for missed appointments and cancelled appointments with less than 24 hours notice. A No-Show/Late-Cancellation fee of $50 may be applied.

I have read and understand the above financial and cancellation policies.

Client's Signature: ____ Date: _________

Parent or Guarantor's Signature: __________________________________ Date: _________