Enlighten
NUTRITION & WELLNESS

ADVANCED NOTICE & PATIENT FINANCIAL RESPONSIBILITY FORM

PATIENT NAME (PLEASE PRINT):_____

You are receiving this form because you have requested a nutrition therapy (the "Requested Service") from Enlighten Nutrition & Wellness, LLC for the above patient (the "Patient"). We suspect that your insurer will not pay for the Requested Service because your health plan has decided not to pay registered dietitians to provide the Requested Services As a result, **THE INSURER WILL NOT PAY FOR THE REQUESTED SERVICE.**

Because the Insurer will not pay for the Requested Service, you have two options (please select one):

☐ **Option #1:** Select Option #1 if, despite being notified of the above, you would like the to receive the Requested Service. **BY SELECTING OPTION #1 AND SIGNING BELOW, YOU AGREE TO BE FINANCIALLY RESPONSIBLE FOR THE TOTAL COST OF ALL SERVICES AND TESTS PERFORMED TODAY. THE INSURER WILL NOT BE BILLED, AND YOU WILL BE REQUIRED TO PAY FOR THE TOTAL COST OF ALL PROVIDED SERVICES AND TESTS AT THE END OF YOUR VISIT TODAY.**

☐ **Option #2**: Select Option #2 if you would like to decline the Requested Service. If you select Option #2, the Patient will not receive the Requested Service today, and the Insurer and you will not be charged for the Requested Service.

By signing below, you agree that (i) you have read and understand this form, (ii) you have selected the above marked option, and (iii) to the extent you have marked Option #1, you are financially responsible for all services and tests performed today for the Patient, you understand that no claim will be submitted to the Insurer, and you agree to pay the full balance at the end of the Patient's visit today.

_____ _____

Signature of Responsible Party Date

Relationship to Patient _____