New Energy Nutrition

Christine P. Mastrangelo, RDN LDN
4 Quail Run Hollow Newburyport, MA 01950
781.248.8238 Email: Christine@ne-nutrition.net

www.newenergynutrition.com

Consent to Treatment:

I have read through all the above information and have been clearly advised of my rights and responsibilities as a client of New Energy Nutrition.

I understand these rights and responsibilities and agree to abide by them. I consent to treatment, and I understand I have a right to receive a copy of this form upon request. I also understand that I can withdraw this consent in writing and terminate at any time.

Financial Policy Agreement:

Please review and acknowledge the following financial policies for New Energy Nutrition. This agreement helps ensure clear communication regarding payment expectations and responsibilities.

1. Payment Responsibility

• Insurance and Out-of-Pocket Payments: I understand that I am responsible for all fees not covered by my insurance, including deductibles, copays, and coinsurance.
• Payment at Time of Service: I agree to pay any self-pay fees at the time of my appointment.
• Card on File Requirement: I agree to keep a credit card on file for use in processing unpaid balances, missed appointment fees, no show fees, and cancellation fees.

2. Cancellation and No-Show Policy

• Cancellation Notice: I agree to provide at least 24 hours' notice for any cancellations or rescheduling.
• I understand the card on file will be charged for any missed appointments or cancellations made without sufficient notice and will incur a fee of: $25
• Late Cancellation Fee (within 24 hours' notice): $25
• No-Show Fee: $25

- Exceptions: I understand that this fee may be waived only in certain circumstances, such as medical emergencies and is at the owner's discretion. Any refunds may take up to 4-5 days or longer once charged.

3. Insurance and Billing Policies

• Insurance Verification: I acknowledge that my insurance benefits will be verified as a courtesy, but verification does not guarantee payment, and I am responsible for any balances remaining after insurance.

• Claim Reprocessing: Our billing team will reprocess any denied claims as necessary, but I understand that I am responsible for unpaid amounts after reprocessing.

• Explanation of Benefits (EOB): I will receive an EOB from my insurance provider detailing the status of each claim.

• In the event that an insurance company rescinds, retracts, or otherwise reverses payment for services previously rendered - commonly referred to as a "clawback"- I (the client) acknowledge and agree to assume full financial responsibility for the recouped amount. Such reversals may result from but are not limited to post-payment audits, eligibility changes, or policy terminations. The client agrees to remit full payment of any outstanding balance within thirty (30) days of notification.

4. Additional Fees

• Session Rate Changes: I understand that session rates may change, and advance notice will be provided.

5. Collections Policy

• Unpaid Balances: I understand that unpaid balances may be subject to collections procedures if not paid within a specified period. Payment plans may be available upon request for larger balances.

By signing below, I acknowledge that I have read, understand and agree to this financial policy.

Client Signature:____

Date:______________________________