

Nutrition Solutions

12900 NE 180th Street • Suite 100 • Bothell, WA 98011 • (425) 385-2809

Office hours are Fridays from 9:00 am – 6:00 pm or by special arrangement.

Patient Fees and Payment Information for Debie McSperitt RD, CD

Full payment of all charges is required at the time of service. I can accept payment by cash or check. Checks that are returned for non-sufficient funds will incur a fee of \$35.00.

Most insurance plans accepted.

Initial Consultation - \$155.00

- 60 minute appointment
- Collect information on medical and social history, dietary habits, and lifestyle
- Screen for nutritional risk
- Prioritize health and nutrition goals
- Present initial recommendations

Follow-up Visit - \$75.00

- 60 minute appointment
- Discuss progress
- Reassess health goals
- Modify or add recommendations as needed

Special Package Pricing

3-Sessions \$225.00 – Includes initial consultation and two follow-up appointments

- Must be used within three months of purchase

5-Sessions \$335.00 – Includes initial consultation and four follow-up appointments

- Must be used within five months of purchase

10-Sessions \$610.00 – Includes initial consultation and nine follow-up appointments

- Must be used within ten months of purchase

Telephone/E-mail Consultation - \$25.00

- 15 minutes
- Response within 24 hours
- Intended to answer additional questions and to provide support for current patients

Shopping Tour - \$75.00

- 60 minute tour in the store of your choice
- Assist with reading food labels
- Propose meal planning ideas
- Introduce unfamiliar foods

Supplements

All supplements must be paid for at the time of purchase.

Cancellation Policy

When you schedule an appointment, this time has been reserved exclusively for you. If you are not able to keep an appointment, you must cancel with at least 24 hours notice to avoid a charge. There is a \$35.00 fee for cancellations with less than 24 hours notice. Full fee will be charged if no notice is received.

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Please read the following information carefully and sign at the bottom of the page prior to treatment. If you have any questions, ask for clarification.

I agree to be treated with medical nutrition therapy. I understand that no implied or stated guarantees have been given to me regarding cure or improvement of my condition as a result of treatment.

Insurance Policy

Although my insurance will be billed for reimbursement, there is no guarantee of insurance coverage. I give permission for the release of information requested by my insurance company to assist in processing my insurance claim. I understand that I am financially responsible for paying any portion of my bill that my insurance does not cover for myself or my dependents. I also understand that the insurance co-payment is due at the time of service.

Insurance can only be billed for in-clinic appointments and does not cover telephone/e-mail consults, appointments outside of the clinic, supplements, or cancellation/no-show fees. I understand these fees are my responsibility.

Payment Policy

Without insurance coverage, I will be considered self-pay and my balance will be collected in full at the time of service.

A late charge of \$10.00 will be assessed for any unpaid balances that are over 30 days past due. An additional \$10.00 will be added monthly until the balance due is paid in full.

There is a \$35.00 fee for cancellations with less than 24-hour notice. Full fee will be charged for my scheduled appointment, if no notice is given.

I agree to the payment policies.

Print Name

Sign Name

Date