



**Financial Policy**

**YOU ARE RESPONSIBLE FOR**

Payment for all services rendered, by Evolution pilates & nutrition. Although we will do our part to submit claims to your insurance company, it is your responsibility to know your benefit and coverage limits. **If for any reason your insurance company fails to reimburse Evolution pilates & nutrition, you will be responsible for payment for all services rendered.**

**PRE-AUTHORIZATION AND REFERRALS**

It is your responsibility to know which services require pre-authorization. If your insurance plan requires a written referral from your Primary Care Physician (PCP) in order for Nutritional Counseling services to be initiated, you are required to provide this facility with the written referral prior to your first treatment.

**INSURANCE PLANS WITH DEDUCTIBLES**

If you have an annual deductible, in which you must pay before your insurance company begins to cover services rendered, you will be responsible to make payment in full for all services rendered until your deductible has been met.

**PLANS OF NON-PARTICIPATION**

We will provide the service of submitting claims to your insurer if we are non-participating. However, if payment is not received within 90 days from the date of service, charges for services rendered to you or your family member become your responsibility. You are responsible for the entire charge less any payment from your insurer. If we do not participate with your secondary (or any non-primary) insurer, you are responsible for that portion of the bill at the time of service.

**PAYMENT TERMS**

Payment is due at the time of service for insurance co-payments, annual deductibles and any services deemed non-covered by your insurance company. We accept Cash, Check, MasterCard and Visa.

Fees:    Insufficient Fund Check Fee: \$10.00                      Missed Appointment Fee: \$20.00

**IN SIGNING THIS POLICY**

You assign your insurance benefits directly to Evolution pilates & nutrition. You authorize Evolution pilates & nutrition to release any medical information for claims reimbursement or clinical purposes. You certify that all information given by you is correct to the best of your knowledge. Your signature on this document serves as a "Signature on File" for all claims submitted to your insurance company for services rendered at Evolution pilates & nutrition.

**PATIENT SIGNATURE** \_\_\_\_\_ **Date:** \_\_\_\_\_

**GUARDIAN SIGNATURE** \_\_\_\_\_ **Date:** \_\_\_\_\_  
(if patient is a minor)

**Nutrition Cancellation Policy** *(effective 11/1/09)*

- All appointments\* require 24 hour notice of cancellation before the scheduled time to avoid being penalized.
- If notice of cancellation is given within 24 - hours of the scheduled appointment, or you fail to appear for any appointment:
  - Nutrition Clients who use our 5-Visit Card will forfeit one visit. If no visits remain on the card, a \$20 fee will be charged to your account.
  - Those who pay through their health insurance, or who pay by any other method, will be charged a \$20 fee. **Note that this fee will NOT be charged to your insurance company, but charged directly to you.**
- If you are 15 minutes late or more, to your appointment we reserve the right to reschedule your appointment. If we are unable to see you on the day that your appointment is scheduled, due to a late arrival, the appointment will be considered missed, and the fees described above will be applied. *If you expect to arrive fifteen minutes late or later, for your scheduled appointment, please contact us as soon as possible so that we can make our best efforts to accommodate you.*
- You are personally responsible for all fees accrued due to late cancellation and/or failing to show up for a scheduled appointment.

**\*Nutrition Members who pay the monthly membership rate will not be charged for any canceled or missed appointments.**

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**Acknowledgement of Receipt of Notice of Privacy Practices and Cancellation Policy**

I, \_\_\_\_\_, have received the Notice of Privacy Practices and Cancellation Policy from Evolution pilates & nutrition.

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**OFFICE USE ONLY**

In lieu of patient signature, I, \_\_\_\_\_, a staff member of Evolution bodywork & nutrition, state that \_\_\_\_\_ has been given our current Notice of Privacy Practices and Cancellation Policy.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_