

## FINANCIAL POLICY

Our primary concern is that you complete your program of care. We ask that you make financial arrangements for payment of all services at the beginning of care, and that you honor them.

All services rendered are charged directly to you, the patient, and you are ultimately responsible for all payments regardless of whether or not this office accepts any form of insurance assignment.

### PRIVATE PAY:

We offer several methods of payment. Payment is due at the time of service. Your balance may be paid by cash, check, or Visa\Mastercard, Discover or American Express. (Returned checks will be subject to a bank fee.)

All payments are expected at the time of service. Patient balances may not exceed \$150 at any time or professional care may be terminated. Payment plans may be available and may be discussed on special circumstances at the doctor's discretion.

### INSURANCE ASSIGNMENT:

We do not accept insurance assignment. You are totally responsible for charges that may be incurred in this office.

If you are covered by a Managed Care policy, our office policy is the same as insurance assignment. If you seek coverage, your managed care plan may not approve all the visits and services you require, and you will be responsible for these and may not receive reimbursement. If your policy requires you to have a referral to our office, you are responsible for obtaining this prior to your appointment(s).

### FAMILY CASH DISCOUNTS:

Family discounts are limited to immediate family members: father, mother, brother, sister, son, daughter. Extended family members are NOT included. 2nd and 3rd family members must be seen within 60 days to be given a discount.

- The first family member to become a patient will receive service at normal fees.
- The second family member receives a 10% discount off of consultation fees, and a 5% discount on nutritional supplements.
- The third family member receives a 25% discount off of consultation fees, and also a 5% discount on nutritional supplements.
- Costs of special lab testing are NOT included. Patients will be fully responsible for full cost of shipping of supplements as well as potential refrigeration & convenience costs.

When you accept a cash discount you must opt-out of filing your insurance. You must first abide by agreements for covered services with ANY managed care plan. If you choose to opt-out of filing your insurance, it must be permitted by your plan. You are totally responsible for checking your insurance agreement.

If you choose to seek reimbursement from your Health Savings Account, or other plans such as Cafeteria Plans, you will ONLY be credited or compensated for the amount you actually paid when permitted by your plan.

### WORKERS COMPENSATION, MEDICARE, & MEDICAID:

We currently do not accept Worker's Compensation. You will be personally responsible for all bills at the time of service. If your insurance decides that treatment should fall under Worker's Compensation, you are personally responsible for all bills.

NJ Nutrition Center, LLC is currently not part of Medicare and cannot bill Medicare for any services. You are totally responsible for charges that may be incurred in this office.

### HOUSE CALLS:

Available by special request at cost of \$225 for initial consultation and \$150 for follow-up consultations. NJ Nutrition Center, LLC reserves the right to arbitrarily deny requests. Clients must be residents of Short Hills, Livingston, West Orange, South Orange, or Maplewood (15-20 minute driving radius from the office).

### MISSED APPOINTMENTS:

THERE IS A 24 HOUR CANCELLATION POLICY. A \$40.00 CHARGE WILL BE BILLED FOR MISSED APPOINTMENTS OR APPOINTMENTS NOT CANCELLED WITHIN 24 HOURS PRIOR TO THE SCHEDULED TIME.

THERE MAY BE AN ADDITIONAL CHARGE OF \$50 FOR ANY EMERGENCY VISITS OR OFFICE VISITS OUTSIDE OF OUR NORMAL OFFICE HOURS

NOTE: NJ Nutrition Center, LLC will refund any overpayments made to us upon completion of custom plan.

In the event that my account becomes delinquent for more than 30 days, I also agree to pay a finance charge of 1.5% per month on my balance due, as well as all reasonable collection costs not to exceed 50% , as well as court costs, attorney fees and interest fees accrued with the collection of this account.

SIGNATURE: \_\_\_\_\_ DATE: \_\_\_\_\_