Rhys Wyman, MS, RD, LDN, Shelley Woolsey, RD, LDN,
Hillary Mamis, MS, RD, LDN, June Skuza, MEd, RD, LDN
68 Main Street Suite # 3 2nd Floor Andover, MA 01810 Phone: 978-474-4478

Nutrition Factory Acknowledgement of Financial Responsibility

Payment: Payment is expected at the time of your appointment. Checks, cash, and credit cards are accepted forms of payment. Checks are to be made payable to Rhys Wyman, Shelley Woolsey, or Nutrition Factory, LLC, depending on your provider.

Fees: Initial visits up to 50 minutes: $250.00. Follow-up visits up to 50 minutes: $200.00. Visit times greater than those listed are charged at $62.50 per quarter hour (15 minutes), and may not be covered by medical insurance.

Appointment Times and No-Show Policy: Appointments are scheduled for a specific time. It is your responsibility to know when you have an appointment. **You will personally be charged $150.00 for any missed visit (no-show).** Insurance companies cannot be billed for no-show fees. No-show fees are due immediately. Rescheduling of visits, will take place following resolution of any no-show bill.

Cancellation Policy: Your business is important to us. If you need to cancel or reschedule any appointment, please give as much advance notice as possible. One cancellation within 24 business hours of an appointment for any reason will be acceptable each year. During that same year, any second or repeat cancellation with less than 24 business hours notice will be charged at $50.00. Same-day cancellation fees are due prior to any future visit. Very poor weather conditions, including driving in snow, are unforeseeable acts of nature and last-minute cancellations due to weather do not count toward same-day cancellation fees. Please be safe.

Medical Insurance: Medical insurance companies may or may not offer you coverage for outpatient nutritional counseling, so you should carefully investigate the type of coverage you have. You are responsible for payment of the above-listed fees. If you do not have a pre-authorized physician referral in place for this or for future visits, you may be responsible for the entire visit fees.

Past Due Accounts: All balances due as determined by your insurance are due immediately. You will be billed for any and all fees for deductibles, coinsurance, and/or unpaid co-payments. Any accounts more than 90 days past due will be sent to a collection agency.

Returned Check Fees: Any checks returned for non-payment will be charged a $25.00 returned check fee.

Patient Written Acknowledgement of our HIPPA statement privacy policy notice: This office complies with state and federal privacy laws. A copy of my privacy practices is available upon request.
☐ Check here if you wish to receive a copy of our privacy statement.
My signature below acknowledges that I hereby accept financial responsibility for present and future nutrition counseling sessions with my provider listed above:

Please print client's name: ____

Signature of responsible party: ____

Date: __________________________

☐Payment, minus copayment, has been temporarily withheld pending medical insurance reimbursement directly to your provider.
☐Copayment received: $___________ Form of payment: Cash/Check #_________ Card Type ______