Ashleigh Sellman Nutrition Counseling, LLC
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Summary of Financial Responsibility/Agreement of Financial Responsibility

Services are offered by Ashleigh Sellman Nutrition Counseling, LLC to client. Payment for services are due at the time the service is rendered. Ashleigh Sellman Nutrition Counseling, LLC does not work in network with any insurance companies. Client is responsible for full payment for services at the time of service. Ashleigh Sellman Nutrition Counseling, LLC will provide clients with an invoice/proof of payment for services. If a client would like to submit an invoice to insurance for an attempt for reimbursement, the client is welcome to do so. Ashleigh Sellman Nutrition Counseling, LLC does not submit invoices to insurance and does not seek to get reimbursement for clients. Client is responsible for communicating with insurance companies to determine their own out-of-network coverage for Ashleigh Sellman Nutrition Counseling, LLC. Not all insurance companies cover nutrition services and each individual client's policy and out of network deductibles are different. It is the client's responsibility to determine coverage and reimbursement.

Please review and initial the following. Your initials signify that you have read and understood your responsibilities.

_____ I understand that I am responsible for payment of fees at the time of every service. I agree to make payment of fees at the time of service.

_____ I understand that it is my responsibility, if I chose, to determine my own out of network coverage and possible reimbursement rates from my insurance, that Ashleigh Sellman Nutrition Counseling, LLC is not responsible.

_____ I understand that if there are any issues with my payment, I will make accurate payment for services within one week of being notified of any issues by Ashleigh Sellman Nutrition Counseling, LLC.

_____ I understand and agree to the fee schedule as outlined by Ashleigh Sellman Nutrition Counseling, LLC.

_____ I understand that if my treatment team requires a team meeting for coordination of my treatment that I am responsible for the fee associated with that time to Ashleigh Sellman Nutrition Counseling, LLC.

Printed name of patient or parent/guardian:_____Date: _____

Signature of Patient or Parent/Guardian of Minor: _____