# Fertility & Midwifery Care Center

## Nutrition/Wellness Consultation and Financial Agreement Waiver

I understand that I am seeking nutrition consultation from this Registered Dietitian who has informed me that she is not a licensed medical doctor, but is a Registered Dietitian/Certified Dietitian/Nutritionist offering wellness and nutrition enhancement ideas. I fully understand that I am not being diagnosed or treated for any disease. I am not being prescribed any drugs, surgery or any other intervention. I am aware of the Registered Dietitian's qualifications and certifications. I am simply seeking wellness enhancing suggestions that could improve my present health and future wellness.

### Client Financial Agreement

- We render our services with the understanding that insurance companies may or may not pay for all, or a portion of our charges.
- Authorizations for medical treatment from your insurance company/doctor do not guarantee full payment for the service.
- Not all insurance companies/third party payors cover for all services, each policy has its own particular stipulations regarding covered services, or amount of coverage.
- Patients are personally responsible for knowing and understanding their own insurance policy, eligibility and coverage.
- Patients are responsible for payment of outstanding deductibles and co-insurance amounts at time of service. Co-payments will be collected at the time of service.
- Patients are financially responsible for payments of all non-authorized procedures and non-covered services.
- Changes in insurance coverage must be reported to our staff promptly to avoid financial responsibility.

I hereby acknowledge that I am eligible for health insurance benefits and coverage. That in the event of ineligibility for coverage of plan benefits, as well as all non-authorized procedures and non-covered services, I understand and agree to be fully financially responsible for payment of all costs incurred during these services and agree to pay all reasonable charges.

PRINTED NAME OF RESPONSIBLE PARTY: _____ DATE: _____

SIGNATURE OF RESPONSIBLE PARTY: _____ RELATIONSHIP TO PATIENT: _____

10228 Dupont Circle Drive, Ste 100 Fort Wayne, IN 46825 Phone: 260.222.7401 Fax: 260.209.5956