PorrazzaNutrition
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PORRAZZANUTRITION POLICIES

Thank you for choosing PorrazzaNutrition for your health and wellness goals! Please review the following policies.
Effective Date: August 25th, 2015, Updated: April 21st, 2017

Insurance Policies

I hereby authorize PorrazzaNutrition to apply for benefits on my behalf for covered services rendered. I certify that all information given is correct, and authorize the release of all information, including medical information, for this or other related claims. I understand that PorrazzaNutrition allows 45 days for my insurance company to make payment. If my insurance company requests for more information, I will provide that information within 7 days. If I fail to respond within 7 days, I will be billed for any and all rendered services. I understand that PorrazzaNutrition will not respond to secondary requests for additional information from my insurance company. I will be responsible for any and all services rendered upon such receipts of request. I understand that PorrazzaNutrition will submit one appeal for each claim denied by my insurance company. If the claim is denied for a second time, I will be responsible for payment of services rendered within 30-days of invoice. I understand that my insurance company does not guarantee that my Medical Nutrition Therapy will be covered and I will be responsible for payment of all services that are not covered. If payment is not received and invoice is past due, I understand that my account will be sent to collections.

Payment

Payment for service is due prior to attending my appointment. I understand that PorrazzaNutrition reserves the right to offer discounts to self-paying clients and that these visits cannot be submitted to my insurance company by PorrazzaNutrition. I understand that I can submit claims to my insurance company and that they may deny my claims. Payments can be made over the phone, via porrazzanutrition.com, or via check. I understand that co-pays are due prior to my appointment. PorrazzaNutrition will not bill me for co-pays. I understand that if I have an outstanding balance when I arrive for my appointment, the Dietitian reserves the right to refuse my appointment.

Referrals

It is my responsibility to obtain any and all referrals prior to each of my visits. If a referral is faxed, I will call to verify it was received.

Failed Payments and Collections

If a check is returned, I will be billed a $15 fee and be required to pay prior to my next appointment. If my account is 90 days past due, I will be sent to a collection agency and will be responsible for any and all collections fees in addition to required PorrazzaNutrition service fees.

No Show/Cancellation Policy (Insured)

Once an appointment is scheduled, I am expected to pay out of pocket for the full fee, equivalent to that reimbursed for attended appointments, unless I provide 24 hours advanced notice of cancellation to PorrazzaNutrition. The fee is the total of my co-payment + insurance reimbursement. Leave notice of cancellations on the PorrazzaNutrition voice mail at 215-378-1001 or via e-mail at Felicia@Porrazzanutrition.com.

No Show/Cancellation Policy (Uninsured)

Once an appointment is scheduled, I am expected to pay out of pocket for the full-established fee, unless I provide 24 hours advanced notice of cancellation. Leave notice of cancellations on the PorrazzaNutrition voice mail at 215-378-1001 or via e-mail at Felicia@Porrazzanutrition.com.

I understand that it is my responsibility to notify PorrazzaNutrition of any medical conditions, medications, or insurance changes. I understand that there is no guarantee of service outcome as related to my health goals and that I am fully responsible for my wellness accomplishments.

Your signature below indicates that you have read the policies listed above and agree to the terms.

Patient: _____ Date: _____

Parent, guardian, or representative: _____ Date: _____

Witness: _____ Date: _____