ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITY

PATIENT INFORMATION

Last Name: First Name: MI:

Address:

City, State:

Relationship to Subscriber:

SUBSCRIBER INFORMATION

Last Name: First Name: MI:

Subscriber Insurance ID: Group ID:

Health Plan Name:

PRACTITIONER INFORMATION

Encompass Nutrition LLC
8119 Shaffer Parkway, Suite A-106, Littleton, CO
ph: 303-949-1177 fax: 303-933-8882

PROPOSED SERVICES

Provision of Nutrition Consultation weekly until symptoms are exhausted or client/patient quality of life is improved significantly. Insurance reimbursement is insufficient to meet the processes/procedures/time necessary for patient care where behavioral nutrition therapies are implemented.
Cost per Visit: Initial Visit fee is $205-250.
Follow-up Cost per 50-60 minute Visit for same diagnosis/condition: $140 (not including urinalysis, food, supplements)

MAINTENANCE/PREVENTATIVE CARE BENEFIT

I understand that my policy may not provide sufficient reimbursement for procedures considered necessary by some to treat and/or prevent manifestations of illness. In other words, the implementation of a treatment protocol with the anticipation of avoiding the onset of clinical manifestation of disease (conditions, illness or symptoms). This includes any services with an asymptomatic patient, including educational materials, supplements.

PRACTITIONER DECLARATION

As the participating practitioner providing services to the patient named on this form, I acknowledge patient/guardian's understanding of financial responsibility must be presented to the patient in writing and signed by the patient/guarantor just prior to rendering of services exceeding or not covered by the benefit. Furthermore, I am required to notify the

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patient/guardian/guarantor just prior to the rendering of non-covered services or treatments exceeding the benefit that they are liable for payment.

Per signing this form, patient/guardian has been notified of his/her financial responsibility in the following situations:

1. When patient has exceeded benefit maximum and additional treatment is recommended
2. When patient's eligibility is unconfirmed. Patient must be informed of his/her ineligibility and that financial responsibility rests with the patient until such time that eligibility is confirmed for the date(s) of service in question.
3. When services, fees, or duration of service are not fully reimbursed by the patient's benefit but are recommended by the practitioner and/or requested by the patient/guardian.

Patient's benefit has been exhausted or reimbursement does not fully cover the visit fee as specified in this agreement, duration of care or procedures for visits and the patient/guardian has requested that he/she will be fully responsible for charges applied and services rendered beyond the scope of reimbursement and estimate of benefit summary.

PATIENT DECLARATION

I understand that I am financially responsible to the participating practitioner named on this form if fees for services recommended are not fully covered or reimbursed according under the patient's health plan. I understand that this practitioner does not confirm benefits or reimbursement rates prior to treatment. I understand that I am responsible for charges for services that may exceed the health insurance plan's maximum benefit.

I understand that my health insurance company will *not* likely pay the full cost per visit.

I will be responsible for any co-payment, deductible, or coinsurance that applies within the balance due included within the cost per visit.

Patient/Guardian Signature: Date:

A copy of this completed form will be available to the patient upon request.