YOUR DIETITIAN FOR DIABETES & WEIGHT CONTROL, LLC
7656 W. Sahara Ste 110
Las Vegas, NV 89117

Dear Valued Patient,

As a Registered Dietitian & Certified Diabetes Educator, my services are personalized to your needs and comfort level. It is my goal to provide you with an understanding of your diabetes, medication, and the effects of diet and exercise on disease management. At each visit, we will set a treatment plan with action items that will positively affect your health. *At this time, I have contracted other Registered Dietitians to work within my business. Your dietitian provider has been chosen by your current medical condition, medications, referring physician and/or your laboratory results.*

I accept all insurances, however, at this time; I am not contracted with all insurance carriers. When insurance companies process a claim for an out-of-network provider one of two things happen; 1) The insurance carrier will apply the entire charged amount to the patient's out-of-network deductible or 2) The insurance company will deny the claim in it's entirety making the subscriber financially responsible for the full billed amount. Understanding the financial burden this would create I have significantly reduced my fees to $85.00 an hour per 60 minute visit & $45.00 for a 30 minute visit for patients who have insurance which I am not yet contracted with.

Financial Policy

Private Insurance Authorization:

I understand that it is the policy of Your Dietitian for Diabetes & Weight Control to accept assignment of benefits with my insurance carrier. Angie Lopez, RDN, LD, CDE and other contracted Registered Dietitian (s) are or are not a contracted provider with my insurance carrier. Until said time that Angie Lopez, RD, CDE becomes contracted, I agree to be financially responsible for $85.00 per hour visit and $45.00 per 30 minute visit. I understand that I will be charged $25.00 for appointments cancelled with less than 24 hour notice, I will incur a $25.00 fee for any returned check(s), and that balances outstanding over 30 days are subject to 1.5% interest per month or 18% per annum.

I understand my signature requests payment be made to Your Dietitian for Diabetes & Weight Control and authorizes release of medical information necessary to pay the claim.

I have read, acknowledge, and agree to the above mentioned terms. This policy will remain in effect until Angie Lopez, RDN, LD, CDE and other contracted Registered Dietitians become contracted providers with my insurance carrier or until I revoke it in writing.

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Patient and/or Responsible Party Signature Date Signed

YOUR DIETITIAN FOR DIABETES & WEIGHT CONTROL, LLC
7656 W. Sahara Ste 110
Las Vegas, Nevada 89117
(702) 525-1105

Financial Policy

Medicare:

I request that payment of authorized benefits be made to Your Dietitian for Diabetes & Weight Control for services rendered to me. I understand my signature requests payment to be made and authorize release of medical information necessary to pay the claim. If other insurance is indicated in box 9a of the CMS 1500 Form, or elsewhere on an electronically submitted claim, my signature authorizes releasing of the information to the insurer or agency shown. Your Dietitian for Diabetes & Weight Control agrees to accept the charge determination of my insurance carrier as the full charge and that I the patient am financially responsible for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of my insurance carrier.
I understand that I will be charged $25.00 for appointments cancelled with less than 24 hour notice, I will incur a $25.00 fee for any returned check(s), and that balances outstanding over 30 days are subject to 1.5% interest per month or 18% per annum.

I have read, acknowledge, and agree to that above stated terms. My authorization will remain in full effect until I revoke it in writing.

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Patient or Responsible Party Signature **Date Signed**

Patients Paying Privately (no insurance)

I understand it is the policy of Your Dietitian for Diabetes & Weight Control to require payment in full at the time of service. I understand that I will be charged $25.00 for appointments cancelled with less than 24 hour notice, I will incur a $25.00 fee for any returned check(s), and that balances outstanding over 30 days are subject to 1.5% interest per month or 18% per annum.

I have read, acknowledge, and agree to that above stated terms. My authorization will remain in full effect until I revoke it in writing.

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Patient or Responsible Party Signature **Date Signed**