Horizon West Nutrition Services

Statement of Patient Financial Responsibility

Patient Name: _____ DOB: _____

I look forward to helping you achieve your health and nutrition goals! Making positive changes to your lifestyle is the cornerstone of good health. This is a statement of our financial policy. You understand that you are obligated to ensure that our fees are paid in full at the time of our visit.

The initial visit is 60 minutes and follow-up sessions are approximately 30 minutes in length. Our fee is $150 which includes your initial nutrition assessment, nutrition counseling based on your specific needs, and 30-minute follow up to be held within 30 days. Our visits must begin on time, so please arrive at our scheduled time.

Please bring this signed form with you along with the completed Nutrition Assessment form, filled out to the best of your ability, along with your signed Acknowledgement of Receipt of Privacy Notice.

Should you need to cancel your appointment, we appreciate at least 24-hours notice.

ACKNOWLEDGEMENT:

I have read and understand the financial policy described above. I agree to pay, promptly and in full, any amounts due to the provider.

Patient Signature _____

Date _____

Authorized Representative Signature _____

Date _____

(use if patient is a minor or otherwise has an authorized representative)