



OFFICE AND PAYMENT POLICY

USE OF INSURANCE BENEFITS

I look forward to working with you to assist you on your path toward health and wellness through nutrition. Making positive lifestyle changes is a key component to good health. Below are my office and payment policies to help you familiarize yourself with my practice.

CONSULTATIONS

Initial visits are schedule for 90 minutes for a full nutrition assessment (up to 60 minutes for minors). Follow-up appointment are schedule for up to 60 minutes. Please be on-time to ensure you will be seen for the full appointment, as the visit will end at the scheduled time.

Please bring the following items, completed to your first appointment; the Registration Form, the Insurance Verification Form, this Office and Payment Policy and a copy of your Insurance Card, if possible. The registration forms can be email to you upon request or be downloaded & printed from my website at www.wellfednutrition.us/forms

If you would prefer to fill out the forms at the time of your initial in-person appointment, the documents can be made available for you at the front desk. Please arrive at least 15 minutes early, if you intend to fill out the forms on-site before your first visit.

REFERRALS

If your insurance requires a referral to see a specialist, you will be required to provide one. Please contact your physician for a referral and bring it will you to the initial visit.

CANCELLATIONS

If you need to cancel a visit, please provide notification at least 24 hours before the time of service. A \$50 fee will be charged for missed appointments without 24-hour notice. Notification of cancellation can be made either through office voicemail or business email.

INSURANCE

When utilizing insurance benefits, it is your responsibility to contact your insurance carrier before your appointment(s) to ensure that the nutrition counseling visit(s) are covered. If your visit(s) are denied by your insurance provider, you will be responsible for payment. Additionally, you will be charged by Well Fed Nutrition for any and all fees not covered by your insurance carrier.

Printed Name _____

Signature _____ Date _____

CONTACT

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