Payment and Cancellation Agreement

- All services can be paid with cash, check, or credit card prior to the start of service.
- Balance and Nourish, LLC accepts Premera BlueCross BlueShield, Meritain, Aetna or Alaska Medicaid. Insurance is billed directly on your behalf.
- I may request a superbill, which I may submit to my insurance company for reimbursement purposes. Submitting a superbill does not guarantee reimbursement to cover services provided.
- All appointment cancellations must be completed 24 hours in advance. Failure to cancel within 24 hours will result in a $50 fee. Repeated cancellations, appointment reschedules, or failure to attend appointments may result in being charged the full price of the session.
- There will be a $30.00 charge for all returned checks.
- Appointments start on time. If I am late, I may use the remaining time of my appointment but not beyond that. I will be required to pay for the entire cost of the visit.
- Any unpaid balances in excess 30 days will be subject to a service charge of 1.5% per month.
- I have an obligation to pay my account in full 90 days from the scheduled date of service. If I do not pay my account in full within this time period, I acknowledge my credit card will be charged for the remaining balance.
- If you have an outstanding balance after 90 days, collected proceedings will be initiated. You will be responsible for the cost of the collection proceedings (including any associated attorney fees, filing fees, and court costs).

I understand that by working with Balance and Nourish, LLC I must comply with the payment and cancellation policies listed above. This not only respects the time and expertise provided by the clinician at Balance and Nourish, but will also help me to make progress on the goals and plans that I have committed to. By signing this agreement, I am indicating that I understand these policies and agree to adhere to them. I also understand that the recommendations and education provided by the clinicians at Balance and Nourish should be not used in place of medical advice.

Client's (or Guardian) Signature:_____
Date:_____

Client's (or Guardian) Printed Name:_____