

Patient or Client Financial Agreement

Laura Chasteen, RDN (Laura Chasteen Nutrition, LLC)
Virtual Medical Nutrition Therapy and Nutrition Counseling
Washington State
Effective January 1, 2026

Patient or Client Information

- Patient or Client Full Name:
 - Patient or Client Date of Birth:
 - Guarantor Full Name (if applicable):
 - Guarantor Date of Birth (if applicable):
 - Guarantor Relationship to Patient or Client (if applicable):
 - Phone Number(s):
 - Email Address:
 - Preferred method of contact:
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Financial Responsibility Acknowledgment

I acknowledge and agree to the following:

1. Financial Responsibility

I understand that I am financially responsible for all services rendered by Laura Chasteen Nutrition, LLC, including charges not covered by insurance or as required by insurance, at the rate published on the date of service.

I understand insurance coverage and payment are determined by individual health plans at the time of service and can not be guaranteed by Laura Chasteen Nutrition, LLC.

2. Insurance Billing

If I am self-pay or using out-of-network benefits, I agree to pay in full at the time of service.

If I am using in-network insurance benefits, I understand that claims will be submitted on my behalf and that I am responsible for any remaining balance after insurance adjudication including copays, deductibles, coinsurance, and non-covered services.

I understand that invoices are issued monthly via e-mail on or before the 28th and payment is processed 3 business days after invoicing.

3. Insurance Verification

I understand that I am responsible for verifying insurance benefits, including coverage for in-network or out-of-network Medical Nutrition Therapy rendered via telehealth by Laura Chasteen, RDN via Laura Chasteen Nutrition, LLC (NPI2: 1396601399). Any insurance information provided by Laura Chasteen Nutrition, LLC is a courtesy and can not guarantee coverage or payment.

4. Card on File Authorization

I authorize Laura Chasteen Nutrition, LLC to maintain a valid credit/debit card, FSA card, or HSA card on file and to charge this card for client-responsible balances, including but not limited to:

- Balances due after insurance processing
- Late cancellation fees
- No-show fees
- Failed payment reprocessing
- Past-due balances

5. Cancellations & No-Shows

I understand that appointments cancelled with fewer than 24 hours' notice may be subject to a late cancellation fee of \$50.00.

I understand that missed appointments without notice ("no shows") may be subject to a no-show fee of \$100.00.

Late cancellation and no show fees will be charged to the card on file at or after 24 hours of the originally scheduled appointment time to allow ample opportunity for me to communicate about extenuating circumstances. Extenuating circumstances are defined at Laura Chasteen Nutrition, LLCs discretion but may include personal or family emergencies and unforeseeable technical issues.

I understand these fees are my responsibility and are not billable to insurance.

6. Past-Due Accounts

I understand that balances outstanding more than 30 days may result in suspension or termination of services until payment is made.

7. Good Faith Estimate (No Surprises Act)

If I am uninsured or self-pay, I understand that I have the right to receive a Good Faith Estimate of expected charges for non-emergency services. I understand that if I receive

a bill that is \$400 or more above my Good Faith Estimate, I may dispute the charges through the U.S. Department of Health and Human Services.