2019 Nutrition Counseling Policies

Our Responsibilities:

We work in partnership with each other and have an understanding that we both have responsibilities in this working relationship. As your registered dietitian, I will provide nutrition therapy and counseling to you. My service includes email and telephone contacts as needed for additional support. All information you share with me will be kept in strict confidence unless I have an explicit agreement from you that states otherwise. I will always render my honest and professional expertise to you in providing recommendations for your success and as such will acknowledge your progress with you. As the client, you agree to be on time for our appointments and respect the payment schedule we have arranged.

Payment:

Payment is expected prior to your first appointment (for virtual appointments) or at the time of your appointment (for in-person meetings). If I am an in-network provider for your insurance company, you are responsible for deductibles, co-insurance, copays and services not covered by your insurance.

Appointments:

Advance scheduling is intended as a convenience to you so that your preferred time is available. In order to provide the most professional session for you, please understand that your appointment will start at your scheduled time. **If you need to cancel or reschedule, please notify me at least 24 hours in advance of your appointment or you will be charged for that scheduled time.** The 2019 rate for cancellation less than 24 hours in advance is $120 for a follow-up visit and the $90 for a phone appointment. Insurance cannot be billed and you are responsible for paying this amount. If you cancel on multiple occasions, advance appointments will be cancelled and you may only make your appointment one at a time.

Confidentiality/ HIPPA:

I understand that all information in nutrition sessions are protected by privacy provisions of the Health Insurance Portability and Accountability Act of 1996, HIPPA, and their implementing regulations. This patient health information may not be released unless I have signed a written authorization release form. I understand any cancellation or modification of this authorization must be in writing.

I, hereby ensure that the above information is true and correct, and recognize responsibility for payment of nutrition counseling services at the time of the session unless prior arrangements have been made with Julianne Hagan RD of Hagan Nutrition Consulting. I understand that I may be charged for appointments not changed or cancelled at least 24 hours prior to the scheduled time of the appointment as explained above (see Appointments).

Signature of responsible party: ____________________________________Date: ___________________

Print Name ____