

Bluegrass Nutrition Counseling, Inc

STATEMENT OF AGREEMENT

1. SCHEDULED APPOINTMENTS

If I will not be able to keep my appointment, I must **CANCEL AT LEAST 24 HOURS IN ADVANCE** so that my reserved time can be made available to others. If I miss my appointment without canceling 24 hours in advance, I understand that insurance companies do not cover missed appointments and **I agree to pay the full fee for that session (copay plus insurance reimbursement fee)**. I understand that my appointment hour is reserved for me and that I should make every effort to keep it.

2. PAYMENTS

I understand that the fee for Bluegrass Nutrition Counseling, Inc services is \$80.00 per hour. I understand that my insurance is a contract between me, my employer, and the insurance company. I understand that Bluegrass Nutrition Counseling, Inc is not a party to that contract. Therefore, I understand that I am fully responsible for any charges not paid by the insurance carrier. I agree to make payments or co-payments at the time of service. Cash, check, MasterCard and Visa are accepted. I am aware that if I do not pay the balance of my bill or make arrangements for payment then my account may be referred to a professional collection agency for any account that is 90 days past due. *If referral to a collection agency becomes necessary, I understand that 40% of the balance will be added to my bill to cover the cost of the collection agency.*

I understand that a \$20.00 fee will be applied should I have a returned check.

3. INSURANCE

I give permission to Bluegrass Nutrition Counseling, Inc to submit necessary insurance claims and information regarding services provided for myself or my dependent. I understand that doing so means that I give permission for the insurance company to have access to my records. I understand that, at times, it may be necessary for such information to be faxed to my insurance company or managed care company. I give permission for such to be faxed.

4. CONFIDENTIALITY

I understand that my treatment is confidential and will not be disclosed to anyone without my written consent.

My signature signifies that I have read and understand this agreement and that I may request a copy for my records.

Date _____

Client Signature _____