

*Bluegrass Nutrition Counseling, Inc.*  
535 West 2<sup>nd</sup> Street, Suite 207  
Lexington, KY 40508  
(859) 388-9152

## STATEMENT OF AGREEMENT

### **1. SCHEDULED APPOINTMENTS**

I understand that my appointment hour is reserved for me and that I should make every effort to keep it. If I will not be able to keep my appointment, I must **CANCEL AT LEAST 24 HOURS ON 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 full fee for that session (co-pay plus insurance reimbursement fee).** You may leave a message 24 hours/day, 7 days/week to cancel an appointment to avoid being charged.

### **2. PAYMENTS**

I understand that the fee for Bluegrass Nutrition Counseling, Inc services is \$120.00 for the Initial Evaluation, \$95.00 per 50 minute session (\$50.00 per ½ hour session).

I understand that my insurance is a contract between my employer, the insurance company and me. I understand that Bluegrass Nutrition Counseling, Inc is not a part of that contract. Therefore, I understand that I am responsible for any charges not covered by my 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 a referral to a collection agency becomes necessary, I agree 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 to submit necessary insurance claims and information regarding services provided for myself or my dependents. 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 my 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 \_\_\_\_\_