STATEMENT OF AGREEMENT AND INFORMED CONSENT

SCHEDULED APPOINTMENTS

I understand that my appointment 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 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 full fee for that session (co-pay plus insurance reimbursement fee). I may leave a message 24 hours/day, 7 days/week to cancel an appointment to avoid being charged.

PAYMENTS

I understand that the fees for Bluegrass Nutrition Counseling services are listed below:

SERVICES associated with insurance coverage	**FEES**	**SERVICES NOT associated with insurance coverage**	**FEES**
Initial Evaluation	$150	Initial Individual No Show or Late Cancellation (<24 hrs advance notice)	$150
50 minute Follow-up	$120	Individual: No Show/Late Cancellation Group: No Show/Late Cancellation	$70 - $120
50 minute Family Session	$150	Returned Check	$15
30 minute Follow-up	$70	Letter Writing	$10/page
15 minute Check-In	$35	Court Preparation/Reports	$150/hour
Group session per individual	TBD	Court Appearances	Initial $200 + $130/hour
Group session per couple	TBD	Telephone/Electronic Consult	$35/15 minutes
		Medical Record Copies	To be determined
		Email Package	To be determined
		Text Package	To be determined
		3-Day Meal Analysis	$100
		Meal Plan Development: Basic Meal Plan Development: Specialized	$120/week + Additional fees TBD

I understand that my insurance is a contract between my employer, the insurance company and me. I understand that Bluegrass Nutrition Counseling is not 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, and major credit cards 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 collection agency for any account that is 90 days past due. If a referral to a collection agency becomes necessary, I agree to pay collection agency fees, attorney fees and court costs.

INSURANCE

I give permission to Bluegrass Nutrition Counseling to submit necessary information to my insurance carrier 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 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.

CONFIDENTIALITY

I understand that my treatment is confidential and will not be disclosed to anyone without my written consent. I also understand that State and Federal laws may require the release of information without written or verbal consent in the following specific situations but not inclusive to: 1) medical or mental health emergencies, 2) clients become a danger to themselves (suicidal thoughts/behaviors/attempts, severe depression, etc) 3) clients become a danger to others (homicidal thoughts/behaviors/attempts).

My signature signifies that I have read and understand this Statement of Agreement and Informed Consent document and that I agree to be bound by the terms in this policy. I may request a copy for my records.

Client Name (Please Print): _____ Date: _____

Client Signature: _____

Guardian Signature if Client is a Dependent: _____

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