

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:

<u>SERVICES associated with insurance coverage</u>	<u>FEES</u>	<u>SERVICES NOT associated with insurance coverage</u>	<u>FEES</u>
Initial Evaluation	\$130	Individual No Show Late Cancellation (<24 hrs advance notice)	\$100
50 minute Follow-up	\$100	Group No Show/Late Cancellation	\$60
50 minute Family Session	\$150	Returned Check	\$15
30 minute Follow-up	\$60	Letter Writing	\$10/page
15 minute Check-In	\$30	Court Preparation/reports	\$100/hour
Group session per individual	\$40	Court appearances	Initial \$200 + \$130/hour
Group session per couple	\$50	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: _____