DC NUTRITION SERVICES

DC Nutrition Services, LLC: Nutrition Counseling Agreement

Thank you for choosing **DC Nutrition Services, LLC** for your nutrition and wellness goals! This agreement summarizes important information you should know about **DC Nutrition Services, LLC's** services and provides your written consent for treatment/care. Please read it carefully, ask any questions and then sign, date, and return the form during your initial consultation. In consideration of our preliminary communications and your receipt of nutrition counseling sessions, you agree to the following:

Services Offered:

DC Nutrition Services, LLC provides nutritional counseling and medical nutrition therapy for the prevention and treatment of specific medical conditions. The dietitian will determine if the care needed involves resources or competencies beyond the scope of her practice, and will provide appropriate referrals. Any recommendations for laboratory tests, diet, and nutritional supplements made will be to support, not replace, medical treatment. The dietitian is not a physician, and the scope of her consultation services does not include treatment or diagnosis of specific illnesses or orders. If you suspect you may have an illness that may require medical attention, then you are encouraged to consult with a licensed physician. There is no guarantee of outcome for any specific recommendation. The initial, in office consultation lasts 60 minutes. Follow up appointments last 45 minutes in office, or may be conducted over the phone as needed. At times, the dietitian will conduct 15 or 30-minute follow up sessions if deemed appropriate. Follow up schedules are determined by the dietitian during your initial consultation and may be modified at any time.

Client Responsibilities:

_____At least 24-hours notice via phone, email, or text message must be provided to the dietitian if you must cancel or reschedule your appointment; otherwise you will be charged your **full** session fee. If you are late for the scheduled appointment you will receive the remainder of the allotted time, but no additional time can be guaranteed.

Payment & Fees:

_____You agree to the designated fees at the time of service. **Initial sessions are $175 and are 60 minutes long; follow up visits are $150 and are 45 minutes long.** Payment is made by credit or debit card, check, or cash at the time of the appointment. You will be billed a $25 fee for any returned check. All payments for a returned check and further payments will be due in cash or money order only. If your account is 90 days past due, it will be sent to a collection agency and you will be responsible for a $25 collections fee. **This office does not accept insurance.** Upon request, DC Nutrition Services, LLC, will provide you with a detailed invoice which you can submit on your own behalf to your insurance company. This office is not responsible for verifying a patient's insurance and will not provide a verification of benefits. The verification of insurance benefits is the sole responsibility of the patient. The patient understands that insurance companies may not reimburse for medical nutrition therapy sessions.

_____Patient understands and agrees that s/he is ultimately responsible for all bills incurred at this office. Patient agrees to promptly remit payment for all costs incident to his/her treatment.

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Communication:

You may communicate with dietitian via email (dcnutritionservices@gmail.com), phone, or text (571-317-1610). You will receive a response in a timely fashion. If your response requires more than 5 minutes to complete, you may be asked to save your question or concern for your next appointment time.

Privacy:

Client information and records are confidential unless your advance permission to disclose, as required by law, is provided. The dietitian may be able to better assist you if she has access to your medical information and is able to communicate openly with your other medical providers. You are responsible for signing a Release of Information if you consent to the disclosure of your medical information. All conversations and information exchanged is confidential under HIPPA code, except as otherwise provided herein.

Termination of Agreement:

This agreement is effective unless and until terminated in writing by client or the dietitian. Either party may terminate this agreement without cause, and at any time, by giving written notice to the other party of his/her intention to terminate the Agreement. In such event, the client shall still be obligated to pay any monies due prior to the termination. A termination of this agreement by either the client or the dietitian shall not limit the dietitian's other legal rights and remedies available under law or equity.

Credit Card Information

Should sessions be missed without proper notification, this credit card will be charged for the session fee. This credit card can also be used for routine payment for services. I acknowledge that **DC Nutrition Services, LLC** is hereby authorized to charge my credit card for payments authorized by me without obtaining any additional signatures.

Card Holder's Name (as it appears on card): _____

Credit Card Billing Address (where credit card statement is mailed):

_____

Credit Card Number: _____

Expiration Date: _____ Security Code: _____ Billing Zip Code: _____

Signature:_____

Please provide an emergency contact:

Name:_____

Relationship:_____

Phone Number(s):_____

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Statement of Understanding : *By signing below, I indicate that I have reviewed and understand the above information and that I have discussed any questions with the provider, and that I agree voluntarily to its terms. I understand that I may withdraw from treatment at any time but if I decide to do this, I will discuss my plan with my provider before doing so.*

Client Name:_____

Signature:_____

DOB:_____ Today's Date:_____