Dr. Kaye-Ann Taylor
Registered Dietitian/Licensed Nutritionist
11309 Lake Underhill Road
Suite 103
Orlando, Florida 32825
www.nutritionandexerciseworks.com

OFFICE POLICY

Medical Insurance
Nutrition & Exercise "Works" is contracted with several insurance companies. However, the coverage of nutrition therapy varies from insurance company to insurance company and from plan to plan within the same insurance company.
It is the client's responsibility to investigate coverage under his or her plan. Services that are not covered by the client's insurance plan become the financial responsibility of the client. Co-payments are expected at the time of appointment.

Payment
Payment is expected at the time of your appointment. Checks are to be made payable to **Nutrition & Exercise Works.** Payment is accepted in the form of cash, checks, Visa and MasterCard, debit cards, and money orders. If you have pre-paid fees, these fees will not be refunded or exchanged and your appointment will be forfeited if you do not show, or if you cancel your appointment with less than 24 hours notice. **There is a $25.00 fee for returned checks. All payments for a returned check and further payments will be due in cash, or money order only. There is a $25.00 fee for any accounts sent to collections.**

Cancellation Policy
When an appointment is scheduled, credit card information will be requested in order to reserve the appointment. This reserve credit card will be charged only if an appointment is cancelled without appropriate notification. Individual appointments are scheduled for specific times and are reserved exclusively for you. As a courtesy to other clients and to the RD, if you must cancel or reschedule, please advise 24 hours in advance to avoid your reserve credit card being charged the full cost of the visit.

Confidentiality
All information disclosed within sessions is confidential as outlined in the HIPPA notice of Privacy Practices.

Consent for Treatment
I have had an opportunity to discuss with the Registered Dietitian and/or with other office personnel, the nature and purpose of Medical Nutrition Therapy. I understand the results are not guaranteed. I acknowledge that I was given a copy of these policies.

Patient's Signature:
Date:

Staff's Signature:
Date: