cKAY NUTRITION

Office Policy & Financial Agreement

I. Consent for Counseling

I give permission to *Carolina Espinosa Rodriguez, MS, RDN* to provide nutrition assessments and a nutrition care plan as deemed appropriate based on my particular medical and dietary needs. I understand it is my responsibility to inform my doctor(s) and my dietitian of any symptoms or relevant information that may help them optimize my nutritional and overall health.

II. Communication

I understand that despite protective measure, emails are not always secure. As a result, correspondence and discussion about my healthcare and nutrition treatment plan between me and my dietitian will be limited to direct contact (face-to-face, by phone), or non-electronic written forms of communication unless I give permission by indicating below:

Carolina Espinosa Rodriguez can[☐]/ cannot[☐] leave a message on my home/cell phone.

Carolina Espinosa Rodriguez can[☐]/ cannot[☐] contact me by email.

III. Cancellation Policy

I understand it is my responsibility to reschedule or cancel my appointment at least 24 hours in advance. If I do not reschedule or cancel my appointment within the required timeframe and/or do not attend a scheduled appointment, I agree to pay the full amount for the services that were scheduled to be provided.

IV. Payment Policy

Paypal, Visa, Mastercard, and American Express are all accepted forms of payment when services are purchased online via the website *cKAY NUTRITION*. If providing services face-to-face, cash or checks with valid identification are accepted forms of payment. There is a $35 fee for any returned checks.

V. Financial Policy

I understand I am responsible for payment in full either in advance via online payment or by cash/check when services are rendered face-to-face.

By signing below, I acknowledge I have read and understand all of the above office and financial policies and that these are in place to maintain my confidentiality and optimal care.

First and Last Name	Signature	mm/dd/yy
Client (Printed Name)	Client (Signature/Reprint name if emailing)	Date

IF THERE ARE ANY QUESTIONS OR CONCERNS REGARDING THE ABOVE POLICIES,
PLEASE CONTACT **CAROLINA ESPINOSA RODRIGUEZ, MS, RDN** AT 732.443.0295

Updated 01/2016