INDIVIDUAL MEDICAL NUTRITION THERAPY AGREEMENT

Between **Vita Nutrition Services** and

Client Name: _____

MEDICAL NUTRITION SESSIONS: The Dietitian will provide the Client medical nutrition therapy by completing a nutrition assessment, utilizing evidence-based nutrition practice guidelines for nutrition intervention, creating an individualized healthy eating plan responsive to the Client's needs, counseling and assisting the Client with behavioral and lifestyle changes and monitoring the Client's progress with additional visits as needed. The Dietitian will be available to the Client during the Client's scheduled session appointment time, unless there is an emergency, and will allow no interruptions during the session, unless there is an emergency.

FEES: Client shall cooperate with procedures and forms necessary for Dietitian to receive payment from Client's insurance company. Client is responsible to pay Dietitian at time of service for all co-payments required by insurance company at the time of service and to pay Dietitian all payments at time of service for which Client has no insurance coverage. If insurance claim denied ultimate responsibility of payment falls to Client.

PRIVACY: Dietitian does not disclose Client's information. Dietitian keeps Client's information and records confidential unless Dietitian receives Client's advance permission to disclose or except as required by law.

ENTIRE AGREEMENT: This Agreement together with the Attachment is the entire Agreement between the parties. This Agreement is made under New Jersey law.

CLIENT RESPONSIBILITIES: Client shall make an effort to talk openly with the Dietitian, participate in and follow through with mutually-established goals, inform Dietitian of any changes in insurance coverage, and is responsible to promptly pay Dietitian for any session not covered by insurance. Client is responsible to make all co-payments or payments at the time of each session. Client shall be responsible to come on time to all scheduled sessions or else cancel **24 hours ahead** of the scheduled session. This will enable for another person who is waiting for an appointment to be scheduled in that appointment slot. Office appointments, which are cancelled with less than 24 hours notification, may be subject to a $**50.00** cancellation fee. Client understands that failure to pay on time and/or excessive no-shows or cancellations even if paid, may result in our decision to close Client's case, cease providing services, with a referral elsewhere, if required. You the Client understand and agree that results and expectations for this therapy vary among individuals and that each individual may not receive the same benefit.

If Client is under eighteen (18) years of age, this Agreement must be signed on behalf of Client by Client's legal guardian.

DIETITIAN: _____

Date: _____

CLIENT/Legal Guardian:

_____

Date: _____

Joanna Hunter Nutrition LLC is DBA Vita Nutrition Services