Policies and Procedures

The following are the policies and procedures for working with ROAM Nutrition:

- All information disclosed within session(s) is confidential unless ROAM Nutrition has an explicit agreement from you that states otherwise. If seen within the community setting, no conversation will be initiated by ROAM Nutrition due to the respect of privacy.
- ROAM Nutrition will exchange information with your team of professionals ONLY by signing the client registration authorizing to release personal healthcare information.
- Any child or adolescent under 18 years old should have a parent in the nutrition counseling process.
- All recommendations during medical nutrition therapy and/or education provided during session(s) provided by ROAM Nutrition should not be used in place of medical advice provided by primary care physician and/or medical team but should be utilized alongside medical advice.

Payment Agreement

- All services may be paid via Square and/or insurance.
    - Credit cards may require up to a 3.5% service charge.
    - Payment(s) is required before appointment and is due at the time an appointment date/time is set. Payment link/invoice will be sent via email **prior** to appointment and is required to be complete before appointment. Package payments will be required before certain appointments throughout the package duration.
- ROAM Nutrition currently accepts _____ insurance. Coming soon!
    - If utilizing insurance for payment, I give ROAM Nutrition permission to bill my insurance company for services.
        - Insurance will be directly billed on your behalf.
        - If you need a physician referral, this must be done at least one week prior to initial session.
    - If policy changes, I am responsible for providing update information to ROAM Nutrition. Failure to do so may result in rejected claims, which I am responsible for paying.
    - I may request a superbill, which I will submit to my insurance company for reimbursement purposes. If a superbill is requested, I am responsible for privately paying at the time of the service. A superbill doesn't guarantee reimbursement to cover the services provided.
    - If my insurance rejects a submitted claim for any reason, I am responsible and I will pay the full fee for the service(s) rendered. I have an obligation to pay my account in full 60 days from insurance rejection. If I do not pay my account in full within this time period. I acknowledge my card will be charged.
- Refunds: out of pocket payment(s) are the only payment that have the ability to be refunded based on adherence to the cancellation-no show policy.
    - Insurance and superbills do not have the ability to be refunded.

Time Management

- All appointments start at the time scheduled. If for any reason I am late, I may use the remaining time of my appointment but appointment will end at scheduled time. I will be required to pay for the entire cost of the consultation.
- If appointment needs to be rescheduled, please provide 24 hours' notice.
- All appointment(s) cancellations must be completed 24 hours in advance. If you cancel within 24 hours of set appointment there will be no refund. If you cancel outside of the 24-hour window, there will be no fee for cancellation and refund or rescheduling can apply.
    - No Show: No refund

Patient Understanding:

- I, hereby ensure that the above information is true and correct, and recognize responsibility for payment of nutrition counseling services at the time of the session unless prior arrangements have been made with ROAM Nutrition. I understand that I may be charged for appointments not rescheduled or canceled at least 24 hours prior to the scheduled time of the appointment.
- I, herby understand that working with ROAM Nutrition I must comply with the nutrition policies listed above. This not only respects the time of both, client and consultant, but allows progress through accountability so that I can meet the goals and plan created during initial session. By signing this agreement, I am indicating that I understand these policies, agree, and will adhere to them in full.

Print Name: _____

Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Card Information: Kept securely on file through Square

Name on Card: _____

Card Number: _____ Expiration Date: _____

Card Security Code (3 digit number located on back of card): _____

Billing Address: _____

Zip Code: _____