Policy and Disclosure

Please read carefully and sign the attached page.

Thank you for your selection of my nutrition services.

Background

I am a Certified Nutritionist in the state of Washington with a Masters degree in Nutrition from Bastyr University. I am a member of the Academy of Nutrition and Dietetics, and Certified Personal Trainer with advanced certifications in medical fitness, senior fitness and health coaching.

The program at Bastyr University emphasizes alternative medicine and counseling skills. My philosophy is to provide individualized services to meet your needs. I believe the best working relationship is an open and cooperative one, in which education towards a healthy lifestyle is one of the most important features.

Appointments and Fees (Fees listed are for self-pay, insurance rates may vary):

Initial Consultation: --- $190

- 90 minute visit
- Collect information on medical/social history, dietary habits, and lifestyle.
- Collection of 24 hour dietary recall for computer analysis.
- Screening for dietary risks of chronic disease.
- Prioritize health goals and present initial recommendations.

Follow-up visit: --- $148

- 60 minute visit.
- Reassess health goals.
- Follow up on recommendations from previous consultation.
- Modify or add recommendations, as needed.
- Review dietary recall and discuss appropriate changes.
- Provide meal planning, food ideas, shopping tips.

Shopping Tours: --- $148

- 60 minute tour.
- Tour the PCC, Whole Foods Market, Ballard Market, or your favorite grocery store.
- Based on client's health goals: can focus on produce section, bulk foods, prepared foods, packaged foods and healthy meal planning.
- Tips on reading food labels.

Telephone/Email consultation ---- $37 per 1/4 hour

- For clients who have had an initial consultation and at least one follow-up visit.
- Intended to answer additional questions and provide support.

Cancellation Policy

When you schedule an appointment, this time has been reserved exclusively for you. If you are not able to keep an appointment, you must notify the office at least **48 hours in advance** (two full business days). This cancellation policy allows for other clients to have the option to reschedule missed appointments or schedule additional appointments with ample notice and for the smooth operation of my practice. There is a $40.00 fee for cancellations with less than 48 hours notice. Full fee will be charged if no notice is received.

Payment

Payments are due at each session, unless arranged in advance by medical insurance. If payment is denied by insurance, the cost of services will be paid by the client. All accounts past a due date of 60 days will accrue interest at a rate of 10% per month. No refunds allowed.

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CONSENT FOR TREATMENT

I hereby agree to nutrition counseling/services with Sheri K. Mar, MS, CN, at the specified fee and payment schedule. I have read and understood all the information provided in the disclosure statement. I understand as with all medical treatment, there are no implied or stated guarantees this treatment will offer improvement or a complete resolution to any, or all conditions I may have. I understand that my record of health care services will be kept for a minimum of three years but no more than seven years after the date of my last visit. This record will be confidential and will not be released to others unless directed by myself, my legal representative, or unless required by law.

This consent shall remain in effect for the duration of treatment.

_____ _____

Patient's Name (Please Print Name) Patient's Signature

_____

Date

Consent for Treatment for a Minor or Dependent Adult

If the patient is a minor, a dependent adult, or for whatever reason not responsible for payment of the services rendered, the person signing this contract accepts full responsibility for payment of the professional fees on the payment plan described above. This person agrees to all of the contract terms as specified herein for the professional services rendered to the patient.

_____ _____

Name of Person Responsible for Payment (Please Print Name) Signature of Person Responsible for Payment

_____

Date