Isabel Smith Nutrition, Inc
330 West 58th St Apt 15G
New York, NY 10019

Phone: 646-712-0770
Fax: (212)-504-2770
Email: hello@isabelsmithnutrition.com

Nutrition & Wellness Counseling Client Agreement

Our Responsibilities: We work in partnership with each other and have an understanding that we both have responsibilities in this working relationship. As your registered dietitian and health coach, we will provide nutrition and wellness consulting to you. We will maintain timeliness of appointments. The service includes in person, phone and email sessions as needed and discussed. All information you share with us will be kept in strict confidence unless we have an explicit agreement from you that states otherwise (noted below). We will always render my honest and professional expertise to you in providing recommendations for your success and as such will acknowledge your progress with you. As the client, you agree to be on time for our appointments and respect the payment schedule we have arranged.

Missed Appointments / Cancellations: In order to provide the most professional session for you, please understand that your appointment will start at your scheduled time. If you need to cancel or reschedule, please notify us at least ***24 hours*** *in advance of your appointment or* ***you will be charged for that scheduled time*** (except in case of illness or emergency).

Billing: Credit cards will be held on file in case the client is lost to followup. Bills will be sent at the end of each month and client has option to pay via credit card, check or another verified method. Fees to be billed and paid as discussed.

My signature here indicates:

- ❑ I have been informed and acknowledge reading the Notice of Privacy Practices for Isabel Smith Nutrition, Inc.
- ❑ I give Isabel Smith Nutrition, Inc. permission to speak with and disclose my protected health information with the treatment providers as necessary.
- ❑ I understand the cancellation policy and that I will be charged for appointments that lack the required notification.
- ❑ I have reviewed the Terms and Conditions and HIPPA policy here.

____ _______________________

Client Date

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (Leave blank if N/A)

Protected Health Information is generally shared by medical facilities and insurance sureties for the care and treatment of the Client. This form provides authorization to share medical information with other practitioners who are within care plan, and with other members of family as to be discussed

Name: _______________________________________ Relationship:______________________________

Please fill out and fax to 212-504-2770 or email: hello@isabelsmithnutrition.com