



- ! I understand that Bay Area Nutrition, LLC has a **24 hour** cancellation policy. It is my responsibility to provide at least **24 hours** notice in the event that I must cancel or reschedule an appointment. If I do not provide **24 hours** notice I will be liable for the payment of my office visit fee of **\$ 120.00**
- ! I understand that Bay Area Nutrition, LLC, as a courtesy, will submit claims for nutrition services to insurance companies that contract with Bay Area Nutrition, LLC.
- ! I understand that Bay Area Nutrition, LLC will submit claims for nutrition services to insurance companies that do not contract with Bay Area Nutrition, LLC when clients have agreed to our fee structure agreement and are willing to pay a deposit for sessions .
- ! I understand that I am responsible for my bill including any co-pay or co-insurance or deductible under my insurance policy.
- ! If I am not insured, or my Insurance Company will not authorize or pay for this visit, I understand that I am responsible for my bill.
- ! I permit a copy of this authorization to be used in place of the original.

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**Client's Name**

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**Client's or Authorized Person's Signature**

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**DATE**