Eat Smart Coach Telephone 571-213-1988
Metro Washington D.C. E-Mail: kathy@EatSmartCoach.com

Welcome to Eat Smart Coach
Your Coach for Health and Wellness
Counseling Agreement

Date: ___________

Client Name____

Address:____
#, street, city, state, zip code
Phone: Cell___________________W:___________________H:___________________

E-Mail Address: _________________________________

Dear ____________________________________,

When we enter into a relationship with our clients we feel it is important to agree on mutual rights and responsibilities. Our goal is to provide supportive, nutrition, fitness, and behavioral therapies, which are
Tailored to your specific needs. On your part, we encourage open communications and a commitment to change through personal and collaborative efforts. The following are our policies and procedures. Please read them carefully and ask us to clarify anything that you do not understand. Please sign a copy of this agreement and return it (by mail, fax, or in person). We look forward to our work together.

Appointment Procedures:
The client will have a pre-arranged date and time for their session (phone call, person, and/or virtual counseling).

Cancellation Procedures:
Once the session is set up, please give at least 24-hour notice. There is a charge of $75.00 for canceled appointments without 24-hour notice or a no-show. We will keep your credit card on file. Exception for Medical Emergencies, & Auto accidents. We value your time as well as ours that we have booked for you.

Payment Procedure:
The first session will begin as soon as this agreement is signed and returned. Please make checks payable to Kathy Glazer. Cash or checks may be used as payment for all services.
Payment is required at the time of service. If the bank returns your check (ISF) the fee is $75.00

If Problems Related to Treatment Arise:
It is important that the Client discusses any concerns or problems and is respectful of the client-Counselor relationship. The Counselor should be notified of any plans to terminate the relationship prematurely

Release of Information/Confidentiality

Sessions are protected by confidentiality which means that information about the Client cannot be given to anyone without express consent(in writing) The client understands that communication by e-mail may not be secure and that archives of E-mail communications may be subject to electronic interception or may be kept by 3rd parties (such as ISP's). A separate HIPA form will be supplied.

Please complete the following items, email them, or bring them to your appointment.

Forms :

1 . Counseling agreement,
2. Health History/Patient Information,
3 Food Record or log.
4. Most recent blood work (if available)

Appointment Fees

Initial Assessment (60-75 minutes) - $160.00
Follow-up Sessions (45-60 minutes) $130-$145
Follow-up Sessions (30 minutes) $ 95.00

Memberships also available

Credit Card Information to be kept on file:

Name on account_______________________________Card name (i.e. M.C. Visa) ____________________

Card Number ___________________________________ , Expiration# _____/_______ CSV #__________,
Zip code______________

Waiver Agreement:

The client hereby waives any claim he/she may have against Eat Smart Coach, their successors, and assigns, relating to failure to obtain their physician's approval to participate in the exercise, nutrition, and or behavioral therapy, or relating to existing injuries or conditions of which the client is aware.

I certify that the information I have provided is correct and I authorize Eat Smart Coach to verify insurance coverage and benefits allowed in accordance with my insurance plan's coverage. I authorize payments to be made directly to Eat Smart Coach for all medical insurance benefits which are payable under the terms of my insurance policy for services provided. I agree to pay any copayment, coinsurance, or deductible as required by my insurance for services provided to me or my dependent. I understand that I am responsible for knowing the terms of my insurance plan.
I am responsible for the fees if the Insurance Co. denies payment.
Reasonable interest, late charges, and direct collections costs (25%), and /or legal fees may be imposed.
There is a $40.00 fee on returned checks.
The client has read the office policy and procedures and understands their rights and responsibilities and those of the counselor. The Client agrees to the conditions of the above agreement.

Client Name (Print) **Date**

Signature of Client/Parent **Date**

Signature of Counselor **Date**

We are looking forward to our relationship and helping you achieve health and wellness.

Regards, Kathy B. Glazer MS, RDN,LD