



## OFFICE POLICIES

Welcome! The following policies have been established to facilitate our work together. Please feel free to comment or ask any questions. I look forward to working with you to find sustainable ways to reach your health goals, feel good about your eating and better about yourself.

### **Confidentiality:**

Sessions are held in strict confidence. A release form will be used to obtain permission to communicate with your physician, or other health care providers with whom you would like me to coordinate your care. I believe in teamwork. Health Information Privacy Protection Act (HIPPA) Notice of Privacy Practices are adhered to. The HIPPA notice is available at your appointment, on my website and by request.

### **To Schedule an Appointment:**

- Contact Laura Biron at by phone or email: 802 578-6191 or [Laura@LivingBetterNutrition.com](mailto:Laura@LivingBetterNutrition.com)
- Appointments are available on:
  - Mondays through Thursdays 10:00 a.m. – 6:00 p.m. in South Burlington at The Adams Center, South Burlington, VT
  - Fridays and most Saturdays at Living Better Nutrition, Stowe, VT

### **Individual Appointment Fees:**

Applies for scheduled in-person office, telephone or video chat sessions.

- 75-minute initial session: \$200.00
- 50-minute follow-up session: \$120.00
- 25-minute follow-up session: \$60.00
- 10-15 minute follow-up session: \$30.00

I will respond to brief phone calls or emails between appointments. If your question or concern requires 15 minutes or more of my time you will be informed and asked to consider scheduling an office or video chat session. You are welcome to leave me a short message to report your progress at any time.

## Payment and Insurance:

Co-payment, deductible or full payment of fees, depending on insurance coverage, **is expected at the start of each visit**. Fees are accepted in the form of cash, check, debit or major credit card. There will be a \$25 fee for all returned checks.

I am a provider for the following insurance companies:

- Blue Cross Blue Shield of Vermont
- MVP Health Care
- Cigna
- United Health Care
- Vermont Medicaid

You are responsible for educating yourself about the terms of your insurance coverage for medical nutrition therapy/nutrition counseling which may be limited in number of sessions covered.

**If I am a contracted provider with your insurance**, a bill will be submitted to your insurance company on your behalf. Your payment responsibility will be limited to any applicable co-pay, deductible or coinsurance, at the time of your session.

**If you have exceeded the number of covered visits by your insurance company**, full payment of fees is expected at the start of each visit.

**If your insurance company denies payment, you are responsible for full payment of fees.**

**If I am not a provider for your insurance company**, full payment of fees is expected at the start of each visit. I will have a separate bill prepared for you so that you may submit it to your insurance company yourself for *possible* reimbursement directly to you. Often, the bill submitted with a letter from your doctor referring you to a registered dietitian nutritionist for your stated diagnosis will help in obtaining coverage. If you choose to submit an insurance claim, any reimbursement will go directly to you, as you will have already paid me for your session.

## Cancellations:

Once a session is scheduled, it becomes your responsibility to attend, reschedule or cancel it. **A minimum of 24 business hours notice to cancel an appointment is required, except in cases of emergencies.** With such notice, I am able to schedule someone else in your time slot. Otherwise, I am unable to fill your appointment time without adequate notice, and will have to charge you a \$50 cancellation fee. This fee is NOT billable to your insurance company. This fee is due by your next appointment.

*Thank you for your cooperation and understanding.*

I, the undersigned client, parent, or guardian, acknowledge and agree that I have read, understood, and accept the terms set forth above for nutrition counseling services provided by Laura Biron, RDN, CD, CEDRD.

\_\_\_\_\_  
Printed Client Name

\_\_\_\_\_  
Printed Parent or Guardian Name (if under 18 years)

\_\_\_\_\_  
Client Signature

\_\_\_\_\_  
Parent or Guardian Signature (if under 18 years)

\_\_\_\_\_  
Date

**\*\* If you are over 18 years old and someone other than you is the financially responsible party, provide the following information: \*\***

*Name:* \_\_\_\_\_

*Address:* \_\_\_\_\_

*Phone Number:* \_\_\_\_\_

\_\_\_\_\_  
Signature of Financially Responsible Party

\_\_\_\_\_  
Date