

ZEST Nutrition

Consent for Care:

I give permission to the Registered Dietitian to provide nutrition assessments and a nutrition care plan as deemed appropriate based on my particular medical and health care needs.

I understand it is my responsibility to inform my doctor(s) and my dietitian of any adverse side effects or changes to my health or well-being that are related to change(s) in my diet, lifestyle, or physical activity so that immediate attention and adjustments can be made to optimize my overall health.

I understand and am informed that results from treatments may vary and are not guaranteed. In addition, I understand that my compliance with diet recommendations, prescribed exercises and lifestyle modification will increase the effectiveness of my care and enhance or maintain the results. I understand that I am in no way obligated to purchase the foods, products or run labs recommended by the Registered Dietitian. I am free to purchase products from any source that I may choose.

Communication:

My signature below gives the staff permission to email and leave messages on my voicemail containing non-protected information such as appointment scheduling.

Cancellation Policy:

I understand it is my responsibility to reschedule or cancel my appointment at least 48 hours in advance. If I do not reschedule or cancel my appointment within the required timeframe and/or do not attend a scheduled appointment, I agree to pay the full amount for the services that were scheduled to be provided. The credit card on file will be charged. If there is no card on file, a bill will be sent to the client's home requesting payment within 30 days. After 30 days, 3% interest will be charged. If payment is still not made by Day 60, the bill may be sent to a collections agency.

Financial Policy:

ZEST Nutrition is a 'fee-for-service' office and is not contracted with any insurance companies. We require payment to be made at the time of service or prior to service. You are 100% responsible for all fees. Cash, checks, credit card, and PayPal are accepted. There is a \$35 fee for any returned check. After receipt of full payment, as a courtesy we can bill your insurance company as an out-of-network provider and you will be reimbursed the amount that your insurance covers.

I understand that any expenses incurred with ZEST Nutrition for myself or any of my minor dependents are my responsibility and not that of any other person or insurance group. I understand that payment is due in full at the time of service.

By signing below, I acknowledge I have read and understand all of the above office and financial policies and procedures and that these are in place to maintain my confidentiality and optimal care. If there are any questions or concerns regarding the above policies or procedures, please contact Colleen Wysocki, MS, RDN at ZEST Nutrition, 970-889-5303 or ZESTNutritionService@gmail.com.

Insurance Company: _____ Grp # _____ Member # _____

Print Name: _____

Signature: _____ Date: _____