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Cancellation / Payment Policy Agreement and HIPPA Privacy Notice

Cancellation Policies

It's not always easy to keep track of life and **we appreciate your giving early notice** if you must cancel. A cancelled appointment delays our work, and may prevent another client from being seen. As such, *we request at least* **one weeks' notice** if you must cancel an appointment. If you do not provide **at least 48 hours notice** (not including Saturday and Sunday), you will be charged for the time reserved for that appointment *unless we can reschedule you the same week or fill the time with another client.* We waive this fee is in the event of an *unexpected* **serious or contagious illness** or ***serious*** **personal emergency**. **We support you in prioritizing self-care,** so if you prefer to finish a project, study, get a message, etc, we encourage you to do so; however, we don't consider these emergencies and are not able to waive fees in these situations.

I agree to these cancellation policies. Initial: _____

We provide **phone or video sessions** if you have a contagious illness or can't get to the office but still want to be seen.

Payment Policies

I understand that **payment is due at the time of service**. I also understand that all amounts not paid within 30 days of the billing date will be assessed monthly late fees. I understand that the fee for any returned checks is $20. Person responsible for payment:

☐ Self ☐ Other: _____

HIPPA Privacy Notice

The Department of Health and Human Services has established a "privacy rule" to help insure that personal health care information (PHI) is protected for privacy. The privacy rule was also created in order to provide a standard for certain health care providers to obtain their patients consent for uses and disclosures of health information about the patient to carry out treatment, payment, or health care operations.

As our client, we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate, and necessary, we provide the minimum necessary information to only those we feel are in need of your PHI and information about treatment, payment or health care operations, in order to provide health care that is in your best interest. We also want you to know that we support your full access to personal medical records. We may have indirect treatment relationships with you and may have to disclose PHI for purposes of treatment, payment or health care options. These entities are most often not required to obtain client consent.

You may refuse to consent to the use of disclosure of your PHI, but this must be in writing. Under this law, we have the right to refuse to treat you should you refuse to disclose your PHI. If you chose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have objections to the form, please ask to speak with the HIPAA Compliance Officer. You have the right to review our privacy notice (at www.eatingwisdom.com), to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

Would you like a copy of this form? †Yes No

Print Client Name: _____ Date: _____

Client signature (or person acting for client): _____