Kat Brown
Registered Dietitian and Yoga Teacher

TEL 650.796.1505 FAX 650.251.4377 EMAIL KATBROWNNUTRITION@GMAIL.COM
WWW.KATBROWNNUTRITION.COM

CANCELLATION, PAYMENT & APPOINTMENT POLICIES- PLEASE READ CAREFULLY AND SIGN BELOW

-Cancellations require 24-hour advance notice. Failure to provide such notice will result in a missed appointment fee of the full cost of the appointment. Missed appointment fees will be charged to the card on file.

-If you are unable to make your scheduled appointment due to an emergency situation, please contact Kat as soon as possible. Situations such as delays caused by traffic, work or child care will not be considered emergencies and the above cancellation policy will apply.

-Parents or legal guardians are legally responsible for all fees of clients under the age of 18. It is the parent/guardian's responsibility to ensure that the appointment is kept or cancelled.

-There will be a $30.00 fee for all returned checks.

-Appointments start on time. If you are late, you may use the remaining time of your appointment but not beyond that. You will be required to pay for the entire cost of the visit.

-Fees include up to 15 minutes of after appointment care coordination and scheduling per session. This may include conference calls or team meetings with other providers, or billing and booking concerns. If that amount of time is exceeded, you will be billed at Kat's hourly rate. If this seems like it will be coming up, you will be informed by Kat prior to being billed.

-Fees are accepted in the form of cash, check or major credit cards, prior to the start of the visit. Please make checks payable to Kathryn Brown. A 3% fee will be added to credit card transactions.

By signing this agreement I indicate that I understand and agree to the above cancellation and payment policies and agree to adhere to them.

Signed (parent/guardian if under 18):_____

Date:_____

Emergency Contact:_____ phone #:_____

Relationship to client: _____

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Fee-For-Service Pricing Structure

Nutrition Counseling

Initial Consultation (1 hour 15 minutes) $200

Follow-up Consultation (50 minutes) $150

Nutrition Counseling Packages*

3 x 50 minute follow-up sessions $420 (saves $10 per session)

Currently Kat does not accept insurance. Sliding scale appointments are available on a case by case basis. A detailed bill (a "superbill") is available upon request which may be submitted to insurance companies for reimbursement. Please call your insurance company to check for your plan's coverage of nutrition visits for CPT (Procedure) code 97802, initial consultation, or 97803, follow up consultation.

Yoga Instruction

Individual session at Kat's office (50 minutes) $125

Group session at Kat's office (50 minutes) $150

Yoga sessions off-site will be priced according to group size and location

Integrative Services

Yoga + Nutrition Counseling session (1 hour 30 minutes) $200

Yoga + Nutrition Counseling session (1 hour) $150

Payments are accepted in the form of cash, check or charge.

*packages are non-refundable

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Authorization for Release of Information- Kat Brown MS RD RYT, Registered Dietitian

Full Name _____

Date of Birth_____ Age_____

If under 18, parent or guardian name_____

Address_____

Email address_____

Primary phone #_____ ☐ cell ☐ home ☐ other

I, _____, give permission to Kat Brown, MS RD
to use and disclose the following protected health information to:
Primary Care MD_____ phone #_____

Specialist MD_____phone #_____

Therapist/Mental Healthcare

Provider_____phone#_____

Family Therapist_____phone#_____

Psychiatrist_____phone #_____

Other_____phone #_____

Other_____phone #_____

This release is reciprocal for all above providers yes no, if not, for whom is the release reciprocal?
_____

Information not to be disclosed (if any): _____
_____

Information will not be released without a valid signature below.

I can cancel this authorization in writing at any time. I understand that Kat Brown will continue to provide care, even if I do not authorize this release.

Patient signature: Date:

Parent/Guardian signature: *(under 18)* Date:

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Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting Kat. This authorization will remain in effect until cancelled.

Credit Card Information

Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX

☐ Other _____

Cardholder Name (as shown on card): _____

Card Number: _____

Expiration Date (mm/yy): _____

CVV code: _____

Cardholder ZIP Code (from credit card billing address): _____

I,_____, authorize_____to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

Customer Signature: Date:

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