Sheri Barke, MPH, RD, CSSD / Nutrition Counseling
25201 Avenue Tibbitts #101 * Valencia, CA 91355 * (661) 886-2720 * sheriRD8@aol.com

CLIENT CONTRACT

Welcome, I'm looking forward to working with you! The following are some of my office policies. Your signature at the bottom of this form indicates your agreement to follow the policies and indicates your consent for treatment by Sheri Barke, MPH, RD, CSSD. Please read over these policies carefully, and we can discuss any questions or concerns you may have about them before our first visit.

PAYMENT / INSURANCE REIMBURSEMENT
Payment is due at the beginning of each office visit. If we are meeting by phone or email, payment must be mailed or Venmo transferred to me prior to each phone or email session. Please pay with cash or checks payable to Sheri Barke. Credit cards are not accepted at this time. My fee schedule follows:

Initial nutrition assessment & consultation (60-70 minutes):	$150
Comprehensive follow up consultation (50-60 minutes):	$125
Moderate follow up consultation (35-45 minutes):	$95
Brief follow up consultation (20-30 minutes):	$65

NOTE: Upon request, I will give you a "super bill" at the end of each visit to submit to your insurance company. Some, but not all, insurance plans will reimburse you for medical nutrition therapy.

MNT MEDICAL REFERRAL
If you are coming to see me for Medical Nutrition Therapy (MNT) for a specific medical diagnosis, please ask your physician or other licensed health care provider to provide a referral for MNT with any special instructions or pertinent lab results that I may use for your treatment. For your convenience, you may use my "Medical Nutrition Therapy (MNT) Referral Form" (attached).

CANCELLATION / LATE
If you need to cancel your appointment, please provide at least 24 hours notice. If you do not provide adequate notice of cancellation, you may be charged a $25 cancellation fee. Please plan to be on time for your sessions. If you are late, I may not be able to meet with you beyond your scheduled time. If we don't get to meet for your entire session, you will still be charged the full amount.

CONFIDENTIALITY / HIPAA COMPLIANCE
Everything that is discussed in session is strictly confidential. No information will be disclosed to any other party without your express consent, except in the event of certain legal requirements. These legal requirements include suspicion of child or elder abuse or situations in which you pose an imminent danger to yourself or others.

With your consent, I will use your protected health information to carry out treatment, payment, and health care operations as specified by my HIPAA Notice of Privacy Practices (full HIPAA Notice is posted on my website under "Forms & Resources"). You have the right to restrict how I use or disclose your protected health information for these purposes; and you have the right to revoke your consent in writing at any time.

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I agree to the above policies, and I understand my privacy rights under HIPAA.

_____	_____	_____
Client Signature	Date	Parent / Guardian Signature (if < 18 yrs. old)