Avery Nutrition

CLIENT AGREEMENT

As a client, I acknowledge and agree to the following conditions as they apply to nutrition counseling and payment of fees to Avery Nutrition:

- I am responsible for understanding my insurance coverage and agree to contact my insurance carrier to determine if treatment is covered.
- I give Elizabeth Avery permission to bill my insurance company for services.
- I agree to contact Elizabeth Avery within one week of any insurance coverage changes.
- I agree to pay the co-payment, if I have one, at every visit or in advance.
- If I am not using insurance, I agree to pay in full at the time of visit.
- If I miss my appointment or cancel it within 24 hours of the start time, I agree to pay $50.
- I understand that the education and recommendations provided by Elizabeth Avery should not be used in place of my doctor's advice.

Signature: _____ **Date:** _____

For questions regarding these policies, please contact Elizabeth Avery.

Phone: 617.721.7865

Email: ElizabethAveryRD@gmail.com

Fax: 866-722-1250