

**Lynn Victory, RD, LD**  
**Cynthia Thomas, RD, LD, CDE**

**Congratulations on your commitment to positive life change!**  
**I look forward to serving you at this time in your life.**

Enclosed are our Office Policies & Procedures, a New Client Questionnaire and a map to the office. Please read and complete all requested information and bring to your first appointment. This will maximize our time together. Thank you!

**Office Policies & Procedures**

1. *Payments:* Payments are due as services are rendered. You will be provided with a form that will serve as your receipt and a coded insurance form for you to file if you wish. Checks, cash, Visa and Master Card are accepted.
2. *Fee Schedule:* Initial assessment-\$150 for 90 min. session. Follow-up appointments-\$80 for 45-60 minute session. We are also available for phone consultations for \$10 per 10 min. There is no charge for a conversation 10 minutes or less.
3. *Cancellations:* Should you need to cancel or reschedule an appointment, kindly give at least a 24 hour notice to avoid being charged a \$50 late fee. Appointments are limited due to a very busy schedule and can be filled with enough notice.
4. *Confidentiality:* Please know that all records, notes and discussions will be kept in strict confidence unless you sign a release form permitting us to speak with your other professionals if needed. In the case of a minor client, discussions with parents will occur if the child or adolescent is engaging in behaviors that endanger his or her health. The minor will be notified that a parent will be contacted. This policy will be discussed at the first session with a parent and client.
5. *Treatment goals:* You will be setting specific goals that are aimed at taking steps toward healthy change. Change takes effort and can be challenging. Homework and reading may also be assigned. If progress is not made over a period of time, your nutrition therapy may be discontinued and/or you may be referred to another health professional.
6. *Referrals:* You may be asked to seek help from another health or mental health professional if it is determined that a team approach is needed.

I have read and agree to comply with the above policies:

\_\_\_\_\_  
Print Your Full Name

\_\_\_\_\_  
Today's Date

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Signature of Parent/Guardian (if applicable)