Dr. Sangeeta Nutrition
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OFFICE/ SERVICES POLICIES

Welcome to Dr. Sangeeta Nutrition. I look forward to working with you to help you achieve your nutrition and lifestyle related goals. The following guidelines have been established to facilitate our work together. Please feel free to ask any questions, as I am here to meet your unique needs up to your satisfaction.

Confidentiality Policy

Your privacy is very important, and all sessions will be held in strict confidence. A permission will be used to speak with your physician and/or other healthcare providers regarding your treatment as needed.

Billing and Insurance Coverage Policy

Payment is due before the time of service. If you have an in-person appointment, payment is due at the beginning of each appointment. If you have a virtual appointment, payment is required 24 hours in advance of your appointment. Failure to provide payment at least 24 hours in advance will cancel your time slot. Cash, check, are accepted. Please talk other options. Please make checks payable to Dr. Sangeeta Nutrition. Note that there is a $25 charge for any returned checks. A receipt will be provided for services rendered. Dr. Sangeeta Nutrition does accept insurance but can also provide you with a receipt that you can submit to your insurance company. Insurance companies may or may not cover nutrition counseling.

Cancellation and Refund Policy

Time has been specifically reserved for your nutrition appointment. If you need to cancel or reschedule your appointment, please do so by contacting Dr. Sangeeta Nutrition via e-mail or phone with a minimum of 48 hours notice from your appointment time. A 48-hour notice must be given prior to the start of a service or class to receive a full refund. Your cooperation with this policy is greatly appreciated.

Lateness Policy

Appointments will be held for 15 minutes only. If you arrive within this time period, you will be seen but your appointment time will not be extended. After 15 minutes, your appointment will be forfeited, and you will be charged.

Your signature below indicates that you understand and agree to the service Polices.

Printed Patient Name:_____

Patient Signature: _____ Date: _____
(Parent or legal guardian must sign if patient is under 18 years of age.)