

Contract for Pricing & Services

Congratulations for choosing to invest in your health and enhance your quality of life! While there are no quick fixes to feeling better, I believe that making the commitment to address your diet over the next few months is an important first step. Whether you need more or less help, my flexible package pricing will allow you to get started on your path to wellness. In the first few meetings, we will work together to create a dietary plan that will allow you to meet **your** goals. For the overwhelming majority of clients, a positive change in diet can dramatically impact how they feel.

There are often barriers to changing your diet. Many clients struggle with understanding package labels, becoming bored with bland foods, utilizing food as a way to cope with stress, and losing focus of the long term goals. I will provide accountability and guidance through this process to help you overcome these challenges.

Packaging Options:

Testing Costs

_____ **LEAP** – \$295 lab, \$50 blood draw **Spectracell** – \$190 insurance (commercial); \$290 without
_____ **A 'la Carte:** \$125/hr for scheduled sessions. Any additional between-session work (phone consultations, recipe ideas, meal plans, grocery shopping trips, pantry clean-outs, sports fueling plans, etc.) will be tracked and billed monthly.

_____ **Monthly:** \$400/month to include 2 sessions, recipe support, meal idea support, between session support, etc

_____ **3 month Basic Package:** \$1000 (plus cost of any testing).

Includes:

90 min Initial Consult

90-120min Follow Up with review of test results, guidance on what to eat for meals, review and input on food logs, plan for implementing the first Phase of LEAP diet

30min Phone Consult 4-7 days into LEAP diet to provide support, troubleshoot issues, recipe ideas for meals and snacks, answer questions, review food products, and address any other issues that have come up

60min session 14 days into LEAP diet for continued support, recipe ideas for meals/snacks, guidance for reintroducing foods, answer questions

60min session 1 month into LEAP diet for continued support, guidance for food reintroduction of untested foods, answer questions, recipe ideas

30min phone consult 2 months into LEAP diet

30min phone consult 3months into LEAP diet

Assistance with supplementation regimen if Spectracell testing is done.

_____ I choose to pay in full upfront

_____ I choose to pay in 2 installments. I authorize Alicia Galvin Smith to charge the below credit card.

When choosing an a la carte option, I ask that you pay in full at each session. You will be billed for missed sessions (\$100) unless you call 24 hours in advance to cancel this appointment. If your appointment is on a MONDAY please give notice of cancellation by the FRIDAY before. Exceptions will be made, of course, in emergency situations.

Once an appointment is scheduled, you are expected to pay out of pocket for the full-established fee. Leave notice of cancellations on my voice mail at 469.340.8449 or via e-mail at alicia@aliciagalvinsmith.com

Visa Mastercard American Express Discover Name on Card: _____

Card Number: _____ Expiration Date: _____

Security Code: _____ Billing Zip Code: _____

Email for receipt: _____

I understand that the once a package is selected, there are no refunds

Signature

Date

Printed Name

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS

I, _____ AUTHORIZE: Alicia Galvin Smith

TO COMMUNICATE PROTECTED HEALTH INFORMATION RELATED TO MY HEALTH RECORDS AND HEALTH CARE TREATMENT BY THE FOLLOWING NON-SECURE MEDIA: Email, text message, phone call/voicemail. This may include communication regarding the following:

- Information related to the scheduling of meetings or other appointments
- Information related to billing and payment
- Information regarding follow ups
- Attachments with blood results, educational handouts, and other forms related to my care

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that I may terminate this authorization at any time.

(Signature of client)

Date