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## Payment, Cancellation and Termination Policies

### Payment Policy

Payment is due in full at the time the service is rendered. Accepted methods of payment include MasterCard, Visa, cheque (made payable to Rosanne Robinson please), and exact cash. Packages must be paid in full during or prior to the initial consultation. The service provided by Blueprint Nutrition is HST-exempt.

All professional services are charged directly to the client. You will be issued a receipt at the completion of each nutrition consultation session OR at the end of the package completion, depending on your preference for health insurance reimbursement purposes, if applicable. We will prepare any necessary forms to help you collect your benefits from insurance companies and will provide you with a detailed receipt.

In Ontario, Registered Dietitians are classified as an "Authorized Medical Practitioner". Even if your extended health insurance plan does not cover dietetic services, keep your receipt and provide it to your accountant to receive a non-refundable tax credit from the government.

### Cancellation Policy

I understand that Blueprint Nutrition has a **24-hour cancellation policy**, and I am aware that I will be charged a fee of \$25.00 for a missed appointment if proper notice is not given by phone (519-574-3614) or email (rosanne@blueprintnutrition.ca). This same integrity is in effect for Blueprint Nutrition. Should we ever have to cancel within 24 hours of the appointment, the next follow up appointment is free.

Understandably, situations can occur that may prevent timely notice. Accordingly, it is at the discretion of Blueprint Nutrition if appointments cancelled less than 24 hours prior will be deemed as services rendered. All no-shows WILL be considered as services rendered and billed accordingly.

### Termination of the Client Relationship

Nutrition counseling services may be terminated at the discretion of Blueprint Nutrition if written notification is provided to a client 30 days in advance of the final appointment. This will include a listing of referrals for continuity of care.

I have read the above policies and agree to be bound by them.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Witness: \_\_\_\_\_