Nutrition and Health Works, LLC

Patient Registration Form

Name:

Home Address:

Telephone: Home ( ) Cell ( )

Email Address:

Occupation:

Date of Birth: Age:

Height: Weight:

Medical History:

Allergies or Intolerances:

Referred by:

Reason for Referral:

Primary Physician:

Physician's Phone:

Therapist's Name:

Therapist's Phone:

How did you hear about Nutrition and Health Works, LLC?

Nutrition and Health Works, LLC

Welcome! I look forward to working with you to help you achieve your nutrition-related goals. The following guidelines are established to facilitate our work together. Please feel free to comment or ask any questions. I am here to meet your needs and offer optimal care.

Confidentiality

All sessions are held in strict confidence. With respect to your privacy, a release form will be used to obtain permission to speak with your other healthcare providers.

Billing and Insurance Coverage

Payment is due at the time of service in the form of cash, personal check or credit card. If you could have your check written before the session begins, we will be able to use the full session to your benefit. **Checks made payable to Nutrition and Health Works, LLC**. There will be a $20 fee for returned checks. Nutrition and Health Works, LLC does not accept insurance at the present time but can provide you with an official receipt of services which you can submit directly to your insurance company. Insurance companies may partially or fully cover nutrition counseling services under the term "Medical Nutrition Therapy." Often, a letter from your doctor referring you to a registered dietitian with a stated diagnosis can help you obtain coverage.

Cancellation Policy

Time has been specifically reserved for your nutrition appointment. If you need to change or cancel your appointment, a minimum of 24 hour notice is requested. Without a minimum of a 24 hour notice, the full session fee will be charged. Your cooperation is appreciated!

Fee Schedule

This fee schedule also applies for scheduled telephone or video sessions.

A la Carte

Kitchen Coaching - Option one: Individual - 90 minutes $250

Kitchen Coaching - Option two: 90 minutes - $125

Packages: Initial + Follow up

- Nutritional counseling: Initial Consult - One hour session = $130
  Follow up session - $ 75

Packages: Follow Up Only

- **1 hour:** Buy 3 one hour sessions and get one free! $225
- **30 minute:** Buy 4 half hour sessions and get one free! $150

Your signature below indicates that you understand and agree to the office polices and payment schedule stated above.

Patient Signature: _____ Date: _____

(Parent or legal guardian must sign if patient is under 18 years of age)

Print Patient's Signature: _____

Nutrition and Health Works, LLC

Credit Card Payment Form

Payment is due at time of service in the form of cash, personal check or credit card. My payment for nutrition counseling includes communication with other members of my treatment team, and reasonable phone/email communication with my dietitian at no extra charge.

My appointment is a reservation of the dietitian's time, keeping other clients from reserving that time. Therefore, even if I do not attend my scheduled appointment, I will be charged for the time reserved. If notice is given in a timely manner, at least 24 hours in advance via email or phone (no text messages), I will not be charged.

Card Holder's Name:

Payment Method: ☐ VISA ☐ Master Card ☐ American Express ☐ Other:

Credit Card Number:

Expiration Date: CCV (3 digit number on back of card):

Card Holder's Billing Address and Zip Code:

My signature below signifies that I have read, understand and agree to abide by the above policies, and grants my permission for Nutrition and Health Works, LLC to charge my credit card or bill me for any appointment not paid for on the day of service, or for any appointment that in not cancelled in a timely manner as described above.

Signature: Date:

[illegible]

NOTICE OF PRIVACY PRACTICES
Nutrition and Health Works LLC

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.
The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program which requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information. As required by "HIPAA," we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for the following purposes: treatment, payment, and health care operations:

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example of this would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services which may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.
You have the following rights with respect to your protected health information which you can exercise by presenting a written request to Juanita Weaver-Reiss at *Nutrition and Health Works, LLC*:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communication of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.

- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of December 1, 2010 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect.

We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.
You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint. Please feel free to contact us for more information.

For more information about "HIPAA" or to file a complaint contact:
The U.S. Department of Health and Human Services
Office of Civil Rights
200 Independence Ave., S.W.
Washington, D.C. 20201
202-619-0257
Toll Free: 1-877-696-6775

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES OF *EAT FREELY NUTRITION*

By my signature below, I acknowledge receipt of the Notice of Privacy Practices.

Patient or legally authorized individual signature	Date
Printed Name	Relationship

[illegible]

Release Form

I hereby consent to participating in nutrition counseling at Eat Freely Nutrition and understand that all information I provide is private, confidential, and protected by law as described in the Eat Freely Nutrition Privacy Practices. When necessary to coordinate my nutrition and healthcare, and as described in the Eat Freely Nutrition Privacy Practices, my protected health information may be obtained from and/or provided to my:

- Primary Care Doctor: _____

Address: _____

_____

Phone: _____ Fax: _____

- Other Healthcare Professional (Relationship: _____)

Name: _____

Address: _____

_____

Phone: _____ Fax: _____

- Psychologist or Counselor: _____

Address: _____

_____

Phone: _____ Fax: _____

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

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