understandingnutrition

www.understandingnutrition.com
6510 Abrams Rd., Suite 302, Dallas, TX  75231 / (214) 503-7100

# PATIENT INFORMATION

**Patient Name:** ______________________ **DOB:** ____/____/______
(month/day/year)

**Address:** ______________________________________

**Home Telephone:** (    ) ______________

**Work Telephone:** (    ) ______________

**Cell/Pager:** (    ) ______________

**Fax Number:** (    ) ______________

**Parent/Guardian Name:** ______________________

**Address:** ______________________________________

**Home Telephone:** (    ) ______________

**Work Telephone:** (    ) ______________

**Cell/Pager:** (    ) ______________

**Fax Number:** (    ) ______________

**Emergency Contact:** ______________

**Phone(s):** (    ) ______________

**Relationship:** ______________

**Referred by:** ______________

**Please list any existing health conditions of which we should be aware:**

______________________________________________

______________________________________________

______________________________________________

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## CONSENT FOR TREATMENT AND AUTHORIZATION FORM FOR USE OF PROTECTED HEALTH INFORMATION

**Patient Name:** ______________________ **Date of Birth:** ___/___/___
(month/day/year)

**Parent/Guardian Name:** ______________________
(Applies only if patient is under 18)

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

**Insurance Company:** ______________________ **Primary Care Doctor:** ______________________

**Address:** ______________________

**Phone:** ( ) ______________ **Fax:** ( ) ______________

**Other Doctor (Relationship:** ______________________) **Name:** ______________________

**Address:** ______________________

**Phone:** ( ) ______________ **Fax:** ( ) ______________

**Psychologist or Counselor:** ______________________

**Address:** ______________________

**Phone:** ( ) ______________ **Fax:** ( ) ______________

Understanding Nutrition and its employees, staff and workers are hereby released from legal responsibility or liability for the release of information authorized herein. I understand that I have the right to revoke this authorization in writing at any time by sending notification to Understanding Nutrition at the address above. I understand that I have the right to (1) inspect or obtain a copy of the protected health information to be provided as permitted under federal and state law, and (2) refuse to sign this authorization. My signature indicates my understanding and acceptance of the above policies.

**Patient Signature:** ______________________

**Date:** ______________

**Parent/Guardian Signature:** ______________________
*(if patient is under 18)*

**Date:** ______________

***(Applies only to patients who are 16 or 17 years of age.)***

I hereby give permission for my child to receive counseling at Understanding Nutrition without a parent or guardian present, and I release Understanding Nutrition and its employees, staff and workers from any and all liability for any incidents or injuries that may occur during my child's appointment or when my child is traveling to or from his/her appointment. I understand that information discussed during counseling sessions will not be released to parents against a minor child's will, except for information of a life-threatening nature. In all cases, a minor child will be encouraged to share appropriate information with a parent.

**Parent/Guardian Signature:** ______________________

**Date:** ______________________

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# NOTICE OF PRIVACY PRACTICES

Effective date: April 14, 2003

*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.*

## OUR LEGAL DUTY AND COMMITMENT TO PRIVACY

The dietitians and staff at Understanding Nutrition are and have always been committed to maintaining the privacy of your protected health information, known as PHI. Because of the Health Care Information Portability and Accountability Act, known as HIPAA, we are now required by law to provide you with this Notice of Privacy Practices and of our legal duties regarding your PHI.

## USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

We provide each patient (and patient's parent, for patients under 18 years of age) with an authorization form to allow us to provide PHI to your other health professionals and your insurance company when it is necessary to coordinate your treatment, to obtain payment on your behalf or on behalf of one of your other health care providers, or for health care operations (the administration of this practice and our patient services).

We are also required or permitted to provide your PHI without additional authorization in the following situations: to you or your personal representatives upon request; when required by the Secretary of the Department of Health and Human Services and for public health activities; to our business associates; for certain incidental uses or disclosures; for face-to-face communications that we make with you regarding products or services; to provide gifts of nominal value to you or your family; to correctional institutions if you are an inmate; to help prevent or control communicable diseases; to your employer in limited circumstances, typically related to workplace injuries or medical surveillance; for reporting abuse, neglect or domestic violence; for health oversight activities authorized by law (such as civil or criminal investigations, audits, licensure and disciplinary proceedings, etc.); for judicial and administrative proceedings (such as in response to court orders or discovery requests); for law enforcement; to funeral directors, coroners and medical examiners; for purposes of organ, eye or tissue donation; to avoid a serious threat of harm to health and safety; for specialized governmental functions (e.g., military operations; national security); for auditing purposes; for certain research studies; for workers' compensation purposes; for emergencies or disaster relief; to persons involved in your care or payment related to your care; for notification purposes with respect to your care, condition, location or death. We may also contact you about appointment reminders, treatment alternatives or with educational information regarding your health condition. In any other situation, we will ask for your written authorization before using or disclosing any of your PHI. If you sign an authorization to use or disclose information, you can later revoke that authorization to stop further uses and disclosures.

## INDIVIDUAL RIGHTS

In most cases, you have the right to look at or obtain a copy of PHI that we maintain about you. We may charge a fee for costs related to your request. We may, under certain circumstances, deny your request but if we do, you can obtain a review of that denial by another licensed health care professional that we designate. You also have the right to receive an "accounting", which lists certain instances when we have disclosed PHI about you for reasons other than treatment, payment or healthcare operations. The request can cover a time period no longer than six years from the date of disclosure. Your first request in a 12-month period is free. After that, we may charge for costs related to additional requests. If you believe that information in your record is incorrect, or if important information is missing, you also have the right to request that we correct the existing information, or add the missing information. We have the right to deny such a request under certain circumstances.

You have the right to request that your health information be communicated to you in a confidential manner such as asking that we contact you at work rather than home. You may request that we restrict how we use or disclose information about you for treatment, payment or healthcare operations, or to persons involved in your care (except when specifically authorized by you, when required by law, or in emergency circumstances). We will consider your request for such restrictions, but are only bound by them if we agree to them. To exercise any of the rights described above, please make a request in writing to Jessica Setnick, at the address above.

## CHANGES IN OUR NOTICE OF PRIVACY PRACTICES

We may change our privacy practices at any time and the new terms shall apply to all PHI about you that we have at the time of the change and to all PHI about you that we maintain in the future. If we make any material changes, we will change our Notice of Privacy Practices and post it in the waiting are of our office. The changes will not take effect until they are reflected in a revised Notice of Privacy Practices. You may request a copy of our Notices of Privacy Practices at any time.

## COMPLAINTS

If you are concerned that we have violated your privacy rights, you may contact Jessica Setnick. You may also send a written complaint to the Secretary of the United States Department of Health and Human Services. You will not be retaliated against for filing a complaint.

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# ACKNOWLEDGMENT OF RECEIPT OF UNDERSTANDING NUTRITION PRIVACY PRACTICES

*Please sign and return this page. You may keep the Notice of Privacy Practices for your records.*

Patient Name ______________________________ Date of Birth _____/_____/_____

Parent/Guardian Name (if patient is under 18) ______________________________

I acknowledge receiving a copy of the Notice of Understanding Nutrition's Privacy Practices on _____/_____/_____.

______________________________________________________
Patient Signature (or Parent/Guardian signature if patient is under 18)

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For Understanding Nutrition use only.

If written acknowledgment was not obtained, please explain below:

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# PAYMENT POLICIES

**Payment for services is due on the day of service by cash, check, or credit card.**

Fees for nutrition counseling are as follows:

New Patient Evaluation:  $225 (90 minutes)
Established Patient Follow-up Visit:  $135 (45 minutes)
Established Patient Follow-up >6 months since last visit:  $180 (60 minutes)

I understand that:

My payment for nutrition counseling visits includes dietitian communication with other members of my treatment team and reasonable phone communication with my dietitian and staff at no extra charge.  Extensive phone communication or phone calls that replace follow-up care, whether scheduled or unscheduled, will be billed at the rate of $45 per quarter hour.

Insurance coverage is not valid for payment.  Upon payment, Understanding Nutrition will provide a coded receipt for services (Superbill) that may be submitted to insurance providers for reimbursement.  These receipts indicate that any reimbursements should be made to the patient or insurance holder, not to Understanding Nutrition.  In the event of a mistaken insurance payment to Understanding Nutrition, the insurance check will be voided and sent back to the insurance company with an explanatory letter, and I will be notified with a copy of this letter and voided check.

Appointments are reservations of the dietitian's time, keeping other patients 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 of my scheduled appointment or 72 hours in advance for Monday appointments), I will not be charged at all.

Credit Card Authorization

Patient Name:________________________________ Date of Birth:_____/_____/_____

☐ Visa   ☐ Mastercard   ☐ American Express

Card Number:________________________________ Expiration Date:_____/_____

Last 3 or 4 numbers from front/back of card ________

My signature below signifies that I have read, understand, and agree to abide by the above policies, and grants my permission to Understanding Nutrition to charge my credit card for any appointment which is not paid for any reason the day of service, or for any appointment that is not cancelled in the timely manner described above.

Signature:____________________________________ Date:_____/_____/_____