Nutrition CounselingGroup

2450 Hollywood Blvd. Suite 200-A, Hollywood, FL 33020
1640 Town Center Circle, Suite 204, Weston, FL 33326

PATIENT INFORMATION

Patient Name: _____ DOB: _____(month/day/year)

Patient's SS#: _____

Occupation:_____

Patient's Address: _____

Cell Phone: _____ OK to leave a message? Yes No

Work Phone: _____ OK to leave a message? Yes No

Home Phone: _____ OK to leave a message? Yes No

Email Address: _____

Parent/Guardian Name: _____

Address (if not same as above): _____

Cell Phone: _____ OK to leave a message? Yes No

Work Phone: _____ OK to leave a message? Yes No

Home Phone: _____ OK to leave a message? Yes No

Emergency Contact: _____

Phone(s): _____

Relationship: _____

Referred By: _____

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

_____

_____

_____

_____

_____

Nutrition CounselingGroup

2450 Hollywood Blvd. Suite 200-A, Hollywood, FL 33020
1640 Town Center Circle, Suite 204, Weston, FL 33326

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

Patient Name: _____ DOB:_____

Parent/Guardian: _____ (applies only to patients under 18)

I hereby consent to participate in nutrition counseling at Nutrition Counseling Group (NCG) 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: _____
Address: _____
_____
Phone: _____Fax: _____

☐ Psychologist or Counselor: _____
Address: _____
_____
Phone: _____Fax: _____

NCG, its independent contractors, and staff 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 NCG at the address below. 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/Guarding Signature _____ Date _____

Nutrition CounselingGroup

2450 Hollywood Blvd. Suite 200-A, Hollywood, FL 33020
1640 Town Center Circle, Suite 204, Weston, FL 33326

NOTICE OF PRIVACY PRACTICES

Effective date: April 14, 2003

THIS NOTICED DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY 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 Nutrition Counseling Group (NCG) are and have always been committed to maintaining the privacy of your protected health information, knows 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 up to provide PHI to your other health professionals and 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 heath 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 inmate; to help prevent or control communicable diseases; to your employer in limited circumstances, typically related to work place 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 request); 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 security0; for auditing purposes; for certain research studies; for workers' compensation purposes; for emergency or disaster relief; to persons involved in 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 your written authorization before using or disclosing any of your PHI. If you sign 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 of 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 licenses 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 12-month period is free. after that, we may charge for costs of 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 describe above, please make a request in writing at the address above.

CHANGES IN OUR NOTICE IF 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 area of our office. the changes will not take effect until the are reflected in a revised Notice of Privacy Practices. You may request a copy of our Notice of Privacy Practices at any time.

COMPLAINTS

If you are concerned that we have violated your privacy rights, you may contact Jessica Gallego. 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 agains for filing a complaint.

Nutrition CounselingGroup

2450 Hollywood Blvd. Suite 200-A, Hollywood, FL 33020
1640 Town Center Circle, Suite 204, Weston, FL 33326

ACKNOWLEDGEMENT OF RECEIPT OF NUTRITION COUNSELING GROUP PRIVACY PRACTICES

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

Patient Name: _____ Bate of Birth _____

Parent/Guardian NAme (if patient is under 18) _____

I acknowledge receiving a copy of Notice of Nutrition Counseling Group's Privacy Practices

_____/_____/_____

_____

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

2450 Hollywood Blvd. Suite 200-A, Hollywood, FL 33020
1640 Town Center Circle, Suite 204, Weston, FL 33326

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: $150 (60 minutes)
Established Patient Follow-up Visit: $80 (30 minutes)
Established Patient Follow-up not seen for >6 months: $120 (60 minutes)

I, _____, am choosing to enter into services with registered dietitian_____. I understand that Nutrition Counseling Group L.L.C is comprised of INDEPENDENT CONTRACTORS who are solely responsible for their own professional practice. Nutrition Counseling Group, LLC and other Practitioners are not liable for the practice of others at the office.

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 charge.

Insurance coverage is not valid for payment. Upon payment, Nutrition Counseling Group 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 Nutrition Counseling Group. In the event of a mistaken insurance payment to Nutrition Counseling Group, 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 to 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.

I fully understand and agree to the above policy and condition.

_____ _____

Patient/Guardian Signature Date