LizFayramRDN Nutrition Counseling Inc.

Date of Initial Appointment:

CLIENT INFORMATION:

Name: Date of Birth:

Gender: Pronouns:

Mailing Address: Billing Address:

PREFERRED CONTACT METHOD (Please fill out and circle):

Email: Cell Phone: Home Phone:

Additional Contact Info:

Phone: Email:

INSURANCE INFORMATION:

Insurance Plan Name: ID#

Insurance Address: Insurance Phone Number:

Subscribers Full Name: Subscribers date of birth:

Relationship to client (Please circle):

Parent Spouse Guardian Self Other

Subscribers Address (if different from above):

Copayment for Medical Nutrition Therapy $_____

OUT OF NETWORK/PRIVATE PAY

Email for billing statements:

Preferred method of payment (please circle): Card Check Invoice/Pay Online

CLIENT TREATMENT AGREEMENT

I, _____, have agreed to meet with Liz Fayram, RDN, LDN, CEDRD, RYT for nutrition therapy and accept the following terms (please initial each section):

_____ If I wish to use my health insurance, I must provide necessary insurance information and a referral from my doctor (when applicable) for the first appointment. Copayments are due at the time of appointment. Private pay rates are listed below for those not using insurance. In the case that my health insurance does not cover nutrition counseling services with Liz Fayram, RDN (including claims that are denied by my health insurance provider or if the claim falls under my deductible) I agree to pay at the following rates:

- Initial Appointment (90 mins): $200

  Subsequent Appointments (45 mins): $150
- Deductible rates vary based on insurance company

_____ I agree to meet for appointments at the scheduled times. If I cannot make an appointment, I will provide 24-hours notice. Otherwise, I agree to pay a fee of $100 for the missed or late cancelled appointment. I understand that insurance cannot be billed for this fee and my credit card on file will automatically be charged for the fee unless otherwise arranged with Liz. This policy is in place to hold my nutrition therapy sessions with Liz Fayram, RDN and support the integrity of the time reserved. In the event there are more than 3 late cancel/no show appointments, I understand that it is in Liz Fayram's discretion to terminate care.

_____ Text/email communication policies: I understand that Liz is available for appointment requests/reschedules by text, phone, and email. However, please be aware that text and email are not be a secure method of communication. Treatment related communication may be reserved for a scheduled private session (telehealth and phone included) with Liz.

Please allow 24 hours business day for a response via text/email/voicemail.

_____ Telehealth Policies: Telehealth and phone sessions can be a helpful part of the nutrition counseling process. Most insurance companies cover these methods, but depends on the specific plan. Please confirm benefits with your insurance provider. Private pay rates for telehealth: Initial $200/Follow up $150.

_____ I agree to keep the following 2 forms of payment (Debit/Credit Card or Check) in secure file to be charged for any balance due beyond 60 days and late cancellation/no show payments. Statements for balances owed are emailed to the patient or guarantor monthly. You will receive notification that your card on file will be charged prior to the transaction via email, after 2 invoices have been sent.

Credit Card & Debit Card Authorizations:

Type 1)

Name on Card:

Billing Address & Zip Code for Card:

Card Type: CVV:

Card Number: Expiration Date:

Type 2)

Name on Card:

Billing Address & Zip Code for Card:

Card Type: CVV:

Card Number: Expiration Date:

_____ Initial here if you would like to authorize copayments/deductible charges on this card directly after nutrition sessions. Copay or Deductible amount per session _____

RDN Initial for secure payment storage _____

_____ I understand that all discussions with Liz Fayram, RDN are confidential and that information from my sessions may not be released to anyone without my written consent. Liz, however, may discuss my treatment with my Medical Doctor and her clinical supervisor providing such discussion will benefit my treatment. If in her professional judgment, Liz believes my safety or that of another person is at risk, she will take appropriate, ethical action.

_____ I understand that safety and privacy are essential to high quality care. It is Liz Fayram's job to assist me in engaging in meaningful behavior changes to help me in my health journey. In order for Liz to support me in my Nutrition Therapy, I understand that my cooperation, honesty, and consent to work in close collaboration is required.

_____ I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) that I have certain rights to privacy regarding my protected health information. I understand that my health information will be used to coordinate my treatment, obtain reimbursement for my care and to conduct normal healthcare operations.

Client Signature_____

Date:_____

Privacy Practices & Authorization to Exchange Information

I acknowledge receipt of Privacy Practices for Liz FayramRDN Nutrition Counseling Inc. in accordance with Health Insurance Portability and Accountability Act (HIPAA). Where applicable, Liz Fayram will exchange information on my behalf as it applies to obtaining reimbursement from my health insurance provider. Liz Fayram is authorized to review my medication history and to exchange medical information with my Primary Care Provider for the purpose of referral authorization and the provision of Medical Nutrition Therapy.

In Addition to my Primary Care Provider, I authorize Liz Fayram to exchange (provide and receive) information pertaining to my treatment with the following provider(s) and/or caregiver(s):

Primary Care Provider: Contact Phone or Email:

Provider or caregiver: Contact Phone or Email:

Provider or caregiver: Contact Phone or Email:

Provider or caregiver: Contact Phone or Email:

Print Name: _____

Sign Name: _____Date:_____

Guardian signature if under 18 years of age:

_____ Date: _____