**

***Christina Scribner MS RD CSSD CEDRD***

• Registered Dietitian • Board Certified Specialist in Sports Dietetics•

•Eating Disorders Specialist •

8119 Shaffer Parkway, Suite A-106 • Littleton, CO 80127 • Phone 303.949.1177 • Fax 303.933.8882

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**PATIENT DEMOGRAPHIC INFORMATION**

(THIS INFORMATION IS TO BE UPDATED WITH ANY INFORMATION CHANGES)

**PATIENT INFORMATION**

Patient Name: **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** Patient’s Social Security Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_ GENDER: M F Marital Status: S M D W

Language Preference if not English: \_\_\_\_\_\_\_\_\_\_\_\_ Other communication issues? N \_\_ Y \_\_ (what?) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt. No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_

Home phone: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work phone: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cell/Pager number: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**GUARANTOR/PARENT INFORMATION**

Emergency Contact Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Emergency Contact Phone: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_

Responsible Party Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_

(Last) (First) (Middle)

Relationship to Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Responsible Party Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Guarantor’s Social Security Number: \_\_\_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_\_\_\_\_

Guarantor’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Apt. No.: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_

Home phone: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell/Pager number: (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employer’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone: (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_

Employer’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT’s INSURANCE INFORMATION \*Please provide Insurance Card and Photo ID**

Company’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance ID Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number for Provider: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Secondary Insurance** Company’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Insurance Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_

Phone number (\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Policy Holder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PATIENT’s REFERRAL INFORMATION**

Primary Care Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_ Zip \_\_\_\_\_\_

Referring Physician \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State \_\_\_\_\_\_ Zip \_\_\_\_\_\_

**Please Read and Sign Both Sides of this Form:**

I hereby authorize my insurance benefits to be paid directly to Christina Scribner. I understand and am responsible for all

charges including my added costs incurred due any effort to collect for services rendered. I realize I am responsible to pay for

non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers.

Signature of Responsible Party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**IMPORTANT OFFICE POLICIES**

**RELEASE OF MEDICAL INFORMATION**

I authorize Christina Scribner and Encompass Nutrition LLC to release the medical

records concerning my son/daughter/self to any physician, hospital, or agency involved in the

care of the patient listed or collection of fees.

**ASSIGNMENT OF MEDICAL BENEFITS**

Top of Form

I authorize my insurance carrier to assign all medical benefits, if applicable, to

Bottom of Form

Christina Scribner and Encompass Nutrition LLC. I also authorize release of treatment

information necessary to process all medical insurance claims and collection of fees.

**PAYMENT POLICY**

Top of Form

The initial visit is longer and runs approximately 60-90 minutes, other visits may be shorter or longer, so are pro-rated. Telephone visits are charged at the normal rate. All medical services provided are directly charged to the patient or responsible party. Payment is expected in full upon receipt of statement or payment arrangements must be made. I understand that a $30/month late fee and collection fees may be applied to accounts overdue 90 days.

**INSURANCE**
See insurance information form. Account balances are due from the responsible party regardless of insurance. Some insurance policies do not cover nutrition counseling, while others cover only limited visits. It is your responsibility to know the specifics of your coverage.

**CANCELLATION POLICY**

24 hours notice is required prior to the appointment to avoid cancellation fee except in documentable emergency. $50 will be charged for the *first* “no show”appointment, to be collected on or before the next appointment. Subsequent “no shows” or “late cancels” will be billed at the regular rate.

Bottom of Form

**REFERRAL POLICY**

I understand that it is my responsibility to obtain a referral through my primary care physician’s

office if required by my insurance company. Failure to do so will result in charges being billed

directly to myself.

**DEBT**
I understand that unpaid balances may be submitted for collection to an outside agency.

**I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THE ABOVE RELEASE**

**OF MEDICAL INFORMATION, PAYMENT, AND OTHER OFFICE POLICIES.**

Signature of Responsible Party: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8119 Shaffer Parkway, Suite A-106, Littleton, CO 80127, Phone: 303-949-1177, Fax: 303-933-8882



**IMPORTANT INFORMATION**

**Insurance Reimbursement For Nutrition Therapy**

To All Patients/Clients:

It is my pleasure and privilege to provide you with caring and competent nutrition therapy.  Many insurance companies are now providing coverage for medical nutrition therapy; however, the coverage may be confusing and complicated.

I participate with Aetna, Anthem/Blue Cross and Blue Shield, Cigna, and Humana. You may have coverage by a company that allows you to see out of network providers for nutrition services with full or partial reimbursement for their services. For example, United Health Care generally does not have RDs within our service area or with the necessary expertise but will often provide my patients with “GAP” exceptions for coverage at the in-network rate. You need to request “preauthorization” or the “GAP” if I am out of network for your insurance or you have a condition for which medical nutrition therapy is a medical necessity (e.g. for eating disorders).

* In order to provide you with the most satisfactory service, find out in advance of coming in whether your insurance company contract covers you for nutrition therapy or office visits by a registered dietitian and for which diagnoses you may be covered.
* Please keep in mind that just because you look on your insurance company website and see the names of providers for medical nutrition therapy this does not mean that your contract with the company includes nutrition services or office visits by nutritionists.
* Every insurance contract is different and generalizations for coverage should not be made.
* It is your responsibility to inquire whether or not your insurance contract covers you for medical nutrition therapy, sometimes referred to as nutrition therapy or nutrition counseling, and for which diagnoses.

Please see below for the questions you may want to ask your insurance company:

      1. Does your insurance contract cover you for (medical) nutrition therapy or office visits by a dietitian? \_\_\_\_\_\_\_\_\_
      2. Do you need a written referral from your doctor or insurance company? \_\_\_\_\_\_\_
      3. How many visits and within what time frame are you eligible? \_\_\_\_\_\_\_\_
      4. For which diagnoses are you covered? \_\_\_\_\_\_\_\_\_
      5. When you speak to your insurance company ask for a *reference number* in regard to the information you are being told, note the *name of the person* you are speaking to and the *date and time*.   \_\_\_\_\_\_\_\_\_\_\_\_

***I have read the statements above and understand that it is my responsibility as a client/patient of encompass Nutrition LLC to pay in full for services provided in the event that my insurance company does not cover these services.  I agree to reimburse Encompass Nutrition LLC for any fee(s) incurred for bounced checks/insufficient funds, and if my account is not paid in full I will be referred to a collection agency.***

 **Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

*** Christina Scribner MS RD CSSD CEDRD, Nutrition Consultant,***

***Encompass Nutrition LLC***

***Authorization for Release of Information***

**What happens if I don't complete this form?**

You are asked to complete the following form to allow for continuity of care with other health care providers and for insurance purposes. If this form is not signed or current, I will continue to protect your private health information.

**What if I change my mind?**

You can change or revoke this process at any time by writing to me at the address above.

**What are some examples of when this might be useful?**

• If an elderly parent wants an adult child to help understand medical treatment instructions

• If someone is helping with billing or payment

• If a friend is helping or family member is helping with health issues

• If a college student wants information shared with a parent

• If an adult child or parent of teenager calls to find out a patient’s appointment time

**How is the information on the form used?**

Anytime your designated person calls or makes a request on your behalf, I will verify the individual has your permission to receive the information and then I will share the information.

Complete the Release of Information form on the reverse side of the next page to let me know to whom I may speak about your information. Check the appropriate boxes to indicate what information I may discuss. You may also send me a letter with this information.

**How can I give others permission to get verbal information about me?**

I have established a process that allows you to tell me who I may talk with about your care. This includes appointment and scheduling information, lab and test results, treatment information and billing information.

***Treatment records are protected under the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), 45 C.F.R. parts 160 & 164, and cannot be disclosed without written consent unless otherwise provided for by the regulations. Consent may be revoked at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as* follows: 360 days after discontinuation of treatment.**

***"Federal Regulation (42 CFR Part 2) prohibits any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to who it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient"***

** Christina Scribner MS RD CSSD CEDRD, Nutrition Consultant,**

**Encompass Nutrition LLC**

**Authorization for Release of Information**

**Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_Age: \_\_\_\_\_**

**Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Home Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_ Work/Cell Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

I give permission to Christina Scribner to release to / and or receive information from my clinical//medical file to facilitate treatment including [ ]  coordination of care and [ ]  continuity of care. Examples of information shared between health care providers may include, but is not limited to:

* Scheduling and appointment information
* Medical information, including my symptoms, diagnosis, medications, treatment plan
* Mental Health & Behavioral information, including my symptoms, diagnosis, medications, treatment plan
* Chemical use, dependence, and abuse information including my symptoms, diagnosis, treatment plan
* Lab and other medical tests/results
* Billing and payment information

I authorize Christina Scribner, Encompass Nutrition LLC, to release any medical or incidental information that may be necessary for processing application for financial benefit. I authorize direct payment of medical benefits by my insurance carrier and any information needed to determine these benefits or related services. I understand that I am financially responsible for paying the balance of service not covered by insurance.

Consider listing parents, health care providers, counselors, coaches below:

1. Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work/Office phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ext: Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work/Office phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ext: Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work/Office phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ext: Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work/Office phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Ext: Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Street address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**I understand that this authorization will be valid for 360 days after I discontinue treatment and will allow sharing of any records shared up to this date and to the date this authorization expires. I understand that I have the right to revoke my permission at any time except where Christina Scribner has already made disclosures in reliance upon this request, that I may cancel this authorization by sending written notice to Christina Scribner, and that the cancellation will take effect when my notice is received by Christina Scribner.**

**Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_**

**Parent/Guardian (if under 18 years old) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_**

Parent/Guardian name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work ph: \_\_\_\_\_\_\_\_\_ Home/Cell ph: \_\_\_\_\_\_

Street address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_City, State, Zip: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Consent for Purposes of Treatment, Payment, Healthcare Operations**

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Summary: This consent form must be completed by a patient/guardian before the first appointment with the nutritionist (with some exceptions). In signing this consent document, the patient is permitting Christina Scribner/Encompass Nutrition LLC to use or disclose the patient’s protected health information to treat the patient, to ensure that the patient’s bills are paid, and to operate the business of the practice.
\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Nutrition Therapy may have both benefits and risks. Treatment often involves discussing distressing behaviors and feelings; you may experience uncomfortable feelings (e.g. sadness, frustration, anger, loneliness, guilt) and even an increase in problematic urges and behaviors. Conversely, committed and consistent nutrition therapy has been shown to result in positive changes in behaviors, attitudes, and health! Your course of treatment and outcome will be unique to you. Nutrition therapy involves a large commitment of time, money and energy, so it is important that you and your dietitian work together to develop a plan to help you reach *your* goals.

I consent to the use or disclosure of my protected health information by Christina Scribner/Encompass Nutrition LLC for the purpose of diagnosing or providing treatment to me or my dependent child, obtaining payment for health care bills, or to conduct health care operations. I understand that diagnosis or treatment by Christina Scribner/Encompass Nutrition LLC may be conditioned upon my consent as evidence by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Christina Scribner/Encompass Nutrition LLC is not required to agree to the restrictions that I may request. However, if Christina Scribner/Encompass Nutrition LLC agrees to a restriction that I request, the restriction is binding.

I have the right to revoke this consent, in writing, at any time, except to the extent that Christina Scribner/Encompass Nutrition LLC has taken action in reliance on this consent.

My “protected health information” means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Christina Scribner’s/Encompass Nutrition LLC’s Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices has been provided to me, is available in the office and on the website, and describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of Christina Scribner/Encompass Nutrition LLC. This Notice of Privacy Practices also describes my rights and the provider’s duties with respect to my protected health information.

Christina Scribner/Encompass Nutrition reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Signature of Patient or Personal Representative\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_

Name of Patient or Personal Representative\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Description of Personal Representative’s Authority\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_