Nutrition with Heart

Courage • Connection • Grace

Practice Policies and Treatment Consent Form

Patient Name: (please print)_____

** Please provide your initials where indicated to acknowledge your review and consent.*
Any questions you may have, please feel free to discuss with Michael before providing your initials.

Insurance Payment Authorization and Financial Responsibility for Treatment:

This is a statement of our financial policy. You understand that you are obligated to ensure that our fees are paid in full. We will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill. You agree that you will pay any deductible and co-payment or co-insurance as determined by your insurance plan. Those payments will be due at the time of service. Many insurance companies have additional requirements or stipulations that may affect your coverage. You are responsible for any amounts not covered or payable by your insurance. If your insurance denies any part of your claim, you agree to be responsible to pay the full balance.

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Initial

By signing this statement, you are authorizing Michael Lynch to complete any necessary insurance claim forms on your behalf. You are also authorizing the release of any medical or other information which may be needed in order to process your claims, including to Nutrition with Heart LLC's private medical billing company Platinum Cash Flow Solutions LLC. If my insurance company does not make payment within 90 days of the claim being submitted, I agree to pay for services, and will receive an invoice from Nutrition with Heart LLC and can submit the payment for reimbursement. Your signature will be kept on file and shall be referred to when insurance claim forms are submitted for healthcare services you have received.

Electronic Communication Authorization of Protected Health Information (PHI):

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Initial

The use of electronic media is a modern and convenient way of sharing information. However, the full confidentiality of any form of communication though electronic media cannot be ensured. If you prefer to communicate via phone, email, or text messaging for issues regarding scheduling, cancelations, and the sharing of information please indicate your authorization by completing your following preferences:

- Primary Phone Number: _____
- Text Number *(if different than primary)*: _____
- Email: _____

Consent to Use Electronic Signatures:

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Initial

You agree that electronic signatures are intended to have the same force and effect as manual signatures. You agree to use electronic documents, notices and contacts "electronic documents."

Emergency Contact:

I give permission to leave detailed health information in case of emergency with the following person:

Name/Relationship/Number: _____

221 4th Ave N.
Edmonds, WA

425.835.2900
425.774.6692

michael@nutritionwithheart.com
nutritionwithheart.com

HIPAA Notice of Privacy Policies:

_____
Initial

I agree that a copy of the Nutrition with Heart LLC "HIPAA Notice of Privacy Practices", which describes the privacy of personal medical information and how that information may be use and disclosed has been made available to me. I may request a paper copy of this Notice or access it on our website at any time.

Appointment Cancellation & No Show Policy:

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Initial

If I cannot attend a scheduled session, I will call cancel and/or reschedule. There will be no fee if a phone message, email, text, or conversation is received before 24 hours of the scheduled appointment time. I understand if I miss or cancel the appointment with less than 24 hours of notice, then I will be charged $35.00 the appointment and agree to pay that balance in full within 3 weeks of the occurrence.

Informed Consent for Nutrition Services:

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Initial

I am employing the counseling service of Nutrition with Heart LLC so that I can obtain information and guidance about diet, nutrition, and related behaviors in order to nourish and support my health and wellness. Nutrition with Heart LLC provides diet analysis and assessment, nutrition education, menu planning, and associated materials. All information provided by the patient is accurate and true to the best ability. Michael Lynch and Nutrition with Heart LLC shall not be held responsible for any information withheld or misinformation provided nor any resulting consequences of this misinformation. Nutrition information, education, and recommendations may be provided as a result of analyzed dietary information, including that analyzed using nutrition analysis software. I understand that Michael Lynch at Nutrition with Heart LLC is a Registered Dietitian, not a physician, and does not dispense medical advice nor prescribe treatment. Nutrition and menu information, education, and planning is in no way to be considered as a substitute for any medications. Any alterations to medication management and therapy should first be reviewed and discussed with your medical treatment team. I agree to hold Nutrition with Heart LLC harmless for claims or damages in connection with our work together, and I understand this is a release of potential liability.

Informed Consent for Fitness Training Services:

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Initial

Nutrition with Heart LLC Fitness Training offers such exercise services as physical activity recommendations and personal. An initial fitness assessment may or may not occur upon initiation of delivery of exercise services and may or may not be repeated throughout the process. I am responsible for conferring with primary care physician prior to initiating exercise programming should it be deemed necessary regarding health status and readiness for exercise. Information relevant to Nutrition with Heart LLC Fitness Training services will be collected. I will not withhold any information pertinent to my health or condition. I realize that unsupervised exercise done on my own is performed at my own risk, even though I may be following guidelines or recommendations establish during my participation with Michael Lynch and Nutrition with Heart LLC Fitness and Performance. I waive and release Michael Lynch and Nutrition with Heart LLC Fitness against any and all claims in any way connected with my participation in this program.

Signature:

My signature below represents an acknowledgement that I and/or my parent, guardian, or responsible person has read through all the above information and have been clearly advised of my rights and responsibilities as a patient of Nutrition with Heart LLC. I understand these rights and responsibilities and agree to abide by them. I consent to treatment, and I understand I have a right to receive a copy of this form upon request. I also understand that I can withdraw this consent in writing and terminate at any time.

Signature: _____ Date: _____

Relationship if not Patient: _____

**If you are the legal guardian or representative appointed by the court for the patient, please attach a copy of this authorization.*

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