# Appetite Health  Treatment, Office Policies, and Privacy Terms for Nutrition Services

**Dear New Patient,**
**Welcome to Appetite Health.**

**We, the healthcare providers look forward to addressing all of your nutritional needs. We encourage your questions and participation in all aspects of your care. This following document is comprised of three sections: 1) office policies and financial agreement, 2) HIPPA privacy policy, and 3) consent to treatment. Please make sure to read through this document in its entirety, mark each box appropriately, and insert your signature at the bottom.**

## 1. OFFICE POLICIES & FINANCIAL AGREEMENT

Services are provided by appointment only. * ☐ I understand

NO-SHOW, LATE, and CANCELLATION FEE
If you arrive to your appointment late, the session will end at the original scheduled time regardless of when it started and full payment is expected. For example, if you arrive to your follow-up session 15 minutes late, you will receive 15-20 minutes of nutrition counseling and be charged for the full appointment time.
It is the policy of Appetite Health to require 24 hours advanced notice for all appointment cancellations allowing maximum availability for clients and to ensure appointment availability is managed appropriately.
• The first time an Appointment is cancelled with less than 24 hours notification or a No-Show / Missed Appointment without notification you will receive an email notification.
• The 2nd cancellation with less than 24 hours' notice will be subject to a $15.00 late cancellation fee.
• A 3rd Missed Appointment/No-Show with less than 24 hours cancellation will be subject to a $25.00 late cancellation/missed appt. fee and client may not be considered a good candidate for further counseling.
Violations of this cancellation policy three (3) or more times in a 6 month period, will be denied any future appointments and also be subject to a $35.00 Missed Appointment/Late cancellation fee.
Late Cancellation and Missed Appointment fees are the sole responsibility of the client and must be paid in full before the client's next appointment.
We understand that special unavoidable circumstances may cause you to cancel within 24 hours. These Exceptions include dangerous weather or medical emergency. Please kindly bring this to our attention and fees in this instance may be waived or refunded with management approval.
Our clinic firmly believes that good practitioner/client relationship is based upon clear understanding and good communication. Questions about cancellation and no-show fees

should be directed to Sarah E. Galicki at sarah@appetitehealth.com.

I give permission for the dietitian or staff to contact me via telephone or email and leave a message that may contain appointment or medical information if I am not available. * ☐ I understand

FEE RESPONSIBILITY

Payments and fees are due at the time of service in the form of either:

- Cash
- Cashier's Check
- Credit Cards: Visa, MasterCard, Discover, American Express and Debit cards.

Appetite Health private pay fees can be found at www.appetitehealth.com and are subject to change at any time without notice. I agreed to confirm all fees prior to services rendered. Since I have chosen to obtain services, I agree to be financially responsible for any and all related charges.

## 2. HIPPA NOTICE OF PRIVACY PRACTICES

*Please review this notice carefully. It describes how medical information about you may be used and disclosed and how you can get access to this information.*

### *USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION*

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

### Treatment:

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. As another example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. * ☐ I understand

### Payment:

Appetite Health does not accept insurance. I have reviewed the fees listed at www.AppetiteHealth.com. I ☐ I understand

understand that payment is due at time of service. *

### Healthcare operations:

We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of students/interns, licensing, and conducting or arranging for other business activities. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name. We may also call you by name in the waiting room when your provider is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. *

☐ I understand

### Use required by law:

We may use or disclose your protected health information in the following situations without your authorization. These situations include: as Required By Law; Public Health issues as required by law; Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners; Funeral Directors; and Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers' Compensation; Inmates; Required Uses and Disclosures. Under the law, we must make disclosures to you and when, required by the Secretary of the Department of Health and Human Services. *

☐ I understand

## *YOUR RIGHTS*

*The following is a statement of your rights with respect to your protected health information.*

### You have the right to inspect and copy your protected health information:

Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information
compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information. *

☐ I understand

## You have the right to request a restriction of your protected health information:

This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional. *

☐ I understand

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. *

☐ I understand

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice. *

☐ I understand

## You may have the right to have your provider amend your protected health information:

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically. *

☐ I understand

If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. *

☐ I understand

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our HIPAA Compliance Officer of your complaint. We will not retaliate against you for

☐ I understand

filing a complaint. *

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number. * ☐ I understand

### *3. INFORMED CONSENT & TERMS OF NUTRITIONAL COUNSELING*

***I have the right to be informed about my health condition(s) and recommended treatment. This disclosure is to help me become better informed by discussing the potential benefits, risks and hazards involved.***

Appetite Health provides one-on-one, personalized counseling with a Registered Dietitian Nutritionist (RDN) that is a Licensed Dietitian (LD) in the state of Texas.
Counseling provided by Dietitians at Appetite Health begins with an assessment of your nutritional status, habits, and needs.

After completing the assessment, you and your dietitian will discuss how to proceed by developing a nutritional plan with personalized, realistic goals. In order for nutrition counseling to be most successful, you will have to attend regular session, work on making changes in-¬between sessions and be honest with your dietitian about your behaviors.

Appetite Health does not dispense medical advice nor prescribe pharmacotherapy. Rater, we provide education to enhance knowledge of health as it relates to foods, dietary supplements, and behaviors associated with eating. While nutritional and vitamin support can be an important compliment to my medical care, I understand nutrition counseling is not a substitute for the diagnosis, treatment, or care of disease by a medical provider.

Nutritional evaluation or testing provided in counseling is not intended for the diagnoses of disease. Rather, these assessment tests are intended as a guide to developing an appropriate health supportive program for me, and to monitor my progress in achieving my goals.

I confirm that Appetite Health and its nutrition services has been explained to me, that I have had the opportunity to ask questions relating to the care process, that I have been provided with the answers to such questions and that I understand the importance of strictly following the dietary recommendations as explained to me verbally and in the materials provided to me, both before and during the period I will be under the care of Appetite Health.

You are free to stop nutrition counseling at any time – please discuss this with your dietitian if you decide to terminate services.

My signature below indicates:

1. I have read and understand the information outlined in this document pertaining to nutrition counseling, payment, insurance, late arrival, no show/cancellation fees, and privacy policy.
2. I have been given a copy of the Appetite Health Notice of HIPAA Privacy Policy or have accessed it on http://www.appetitehealth.com.
3. I understand that email is not a secure means of communication and I will not hold Appetite Health or their dietitians liable for any breach of confidentiality that may result from the use of email.
4. I understand that Dietitians and through Appetite Health will keep therapy notes as a record of our work together. These notes document the topics that we talk about, interventions used, and treatment plan or any other considerations that may be helpful to your work with me. Records will be stored in a secure location.
5. I authorize the release of any medical or other information necessary to persons I deem fit and declaration of those persons will be provided in writing.
6. I authorize payment of medical benefits to Appetite Health for services rendered.
7. I understand that nutrition-counseling services may be terminated at the discretion of the Appetite Health team if written notification is provided to a client 30 days in advance of final appointment. This will include a listing of referrals for continuity of care.
8. I consent to receiving treatment through Appetite Health.

***By signing and submitting this form I acknowledge that I have been provided ample opportunity to read this document or that it has been read to me. I understand the above-stated office policies and the financial agreement with Appetite Health, and will comply with them in all respects. I acknowledge that I have received the Notice of the Privacy Practices. Lastly, I understand all of the above and give my oral and written consent to the evaluation and treatment to cover the entire course of treatments for my present condition and any future conditions for which I seek treatment.***

**Please submit your digital signature below.**

**PATIENT SIGNATURE :** _____

Name of Patient: * _____

Today's Date: _____