



Diana Dugan Richards RDN LDN  
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(617) 678-0607

## **Nutrition Counseling Client Agreement**

Welcome to Namaste Nutrition! I value the time we spend together. I join you with a fusion of medical nutrition therapy and psychology as a nutrition therapist to address the whole of you on this journey of exploration for what your body needs. I believe in being transparent and authentic about our work together. The deepest transformation happens when we meet regularly, usually every other week, for a length of time to be determined by your needs. My intention is to create a safe space for your personal development to support the shifts you desire.

**Missed Appointments / Cancellations:** Arriving on time means we get the most out of the session. As unplanned issues may arise that lead you to reschedule, *24 hours advanced notice is needed; if less than 24 hours, a late fee of \$100 will be assessed for that scheduled time.* If availability is open in the same week for you to make up the missed appointment, there will be no fee assessed.

**Payment Options:** *(Co-pays or private pay fees accepted by check, cash or credit card at the start of the session.)*

Insurance plans accepted:  
Blue Cross Blue Shield of Massachusetts  
Harvard Pilgrim Health Care  
Tufts Health Plan  
United Healthcare  
Cigna  
Aetna

By signing this form, you acknowledge you have read the Notice of Privacy Practices for Diana Dugan Richards RDN LDN and give Diana Dugan Richards RDN LDN permission to speak with and disclose your protected health information with the treatment providers listed on the Client Registration form.

**Credit Card on File:** \_\_\_\_\_ (card number)

Exp date: \_\_\_\_\_ mos \_\_\_\_\_ year \_\_\_\_\_ Security code on back

*Your credit card will only be charged for payment of fees or co-pays and late cancellations.*

\_\_\_\_\_  
Client

\_\_\_\_\_  
Date



## Client Registration

### Demographic Information

Name					Date of Birth		
Street Address		City		State		Zip	
Marital Status			SSN			Gender	

**Contact Information** Please initial if I may leave a voice message for you. \_\_\_\_\_ (initial)

Cell Phone		Email	
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### Primary Care Physician

Name					Phone		
Address		City		State		Zip	
How long have you seen your PCP? _____ Months _____ Years Are they aware of your nutrition needs? _____ Yes _____ No							

### Psychotherapist / Counselor

Name					Phone #		
Address		City		State		Zip	
How long have you seen your therapist? _____ Months _____ Years Are they aware of your nutrition needs? _____ Yes _____ No							

### Psychiatrist / Psychopharmacologist

Name					Phone #		
Address		City		State		Zip	
How long have you seen your prescriber? _____ Months _____ Years Are they aware of your nutrition needs? _____ Yes _____ No							