namaste nutrition

Diana Dugan Richards RDN LDN
23 Main St., Suite A, Watertown MA 02472
dianaduganrichards@gmail.com
(617) 678-0607

Nutrition Counseling Client Agreement

Our Responsibilities: We share responsibilities as partners in our work together. As your registered dietitian and nutrition therapist, I provide you with medical nutrition therapy and counseling and will be on time for our appointments. Information you share with me is in strict confidence unless you state otherwise as noted below. You can expect my honest evaluation and professional skills in recommendations for your success and acknowledgement of your progress. You agree to arrive on time for our appointments and respect the payment schedule and cancellation policy we have arranged.

Missed Appointments / Cancellations: Arriving on time offers you a full professional session. Arriving late means your session will be shortened to accommodate the needs of others with appointments following yours. As unplanned issues may arise that lead you to reschedule your appointment, ***24 hours notice is needed*** *in advance of your appointment; if less than 24 hours notice*, ***you will be charged $100 for that scheduled time***. If there is availability in the same week for you to make up the missed appointment, there will be no charge.

Payment Options: *(Co-pays or private pay fees accepted by check, cash or credit card payable 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

Your signature here indicates:

- You acknowledge reading the Notice of Privacy Practices for Diana Dugan Richards RDN LDN.
- You 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.
- You understand the cancellation policy and note you will be charged for appointments that lack required notification.

Credit Card on File: _____ (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

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION
Protected Health Information is generally shared by medical facilities and insurance sureties for the care and treatment of the Client. Authorization must be given by the Client (other than minor child) for the release of information to anyone other than medical facilities and your insurance company. Do you wish to authorize anyone, ***other than yourself,*** to have access to your medical information (i.e.; spouse, child, attorney)? If so, whom?

Name: _____ Relationship:_____

National Provider Number (NPI): 1629177266

Massachusetts License #1630
Georgia License #LD005083

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Client Registration

Client Information

Name					Date of Birth		
Address		City		State		Zip	
Marital Status (circle)	Single Married Divorced Widowed		SSN			Gender	

Contact Information (Please circle your preferred method of contact which indicates I may leave a voice message for you)

Telephone (Daytime)		Cell Phone	
Telephone (Evening)		Email	

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