namaste nutrition

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 as you explore what your body needs. I believe in being transparent and authentic in our work together. The deepest transformation happens when we meet regularly, usually every two weeks, 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: When clear expectations are set on the front end, there's a greater sense of clarity and trust and that leads to a successful relationship between us. Arriving on time means we get the most out of the session. As unplanned issues may arise that may 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-pay will be billed to you by Good Measures. Private pay fees are accepted by check, cash or credit card at the start of the session.)* Namaste Nutrition uses Square and Ivy Pay, both encrypted payment platforms for your credit card payments.

Insurance plans accepted:

Blue Cross Blue Shield of Massachusetts
Harvard Pilgrim Health Care
Tufts Health Plan
Allways
Cigna

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: _____ CVC security code on back _____ Zip code_____

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

_____ _____
Client signature Date

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Client Registration

Contact Information

Please initial if I may leave a voice message for you. _____*(initial)*

Name:_____ Date of Birth:_____ SSN: _____

Address:_____ City:_____ State:_____ Zip:_____

Emergency contact:_____ Cell phone:_____ Relationship:_____

Primary Care Physician

Name:_____ Email (if known):_____

Address:_____ City:_____ State:_____ Zip:_____

Are they aware of your nutrition needs?_____ (**If yes, please obtain an order for nutrition counseling for Harvard Pilgrim insurance** and fax to 603-421-9532 or 888-286-2455.)

Psychotherapist / Counselor

Name:_____ Email (if known):_____

Address:_____ City:_____ State:_____ Zip:_____

Psychiatrist / Psychopharmacologist

Name:_____ Email (if known):_____

Address:_____ City:_____ State:_____ Zip:_____

Are they aware of your nutrition needs?_____ (If yes, have you been advised of any drug-supplement interactions?)

Yes:_____ No:_____