



New Client Form Checklist

Please print and fill out the checklist of documents to your first appointment. We will review all paperwork together during the first appointment and it will be kept in your medical record file. I look forward to working with you!

Authorization for Release of Information. Please complete, print and sign this form if you would like me to be able to talk to any of your other healthcare providers (therapist, primary care physician etc.) or family members (spouse, parents if over the age of 18). Please complete a form for each individual you would like me to speak with. I will have extra copies at the first appointment if you need additional copies. (Page 1). Working with your other healthcare providers will give me the best picture of your nutritional needs.

Financial Agreement. Please read, print and sign page 2 (Financial Agreement and Cancellation Policy).

Informed Consent. Please read, print and sign pages 4-5.

HIPPA Privacy Practices. Please read page 6-7, and print and sign page 8. (Acknowledgement/Receipt of Notice of Privacy Practices)

Communication Agreement. Please read, print and sign page 7 (Communication Agreement)



Authorization For Release of Information

Client Name: _____ Date of Birth: _____

Client Address: _____

City, State, Zip: _____ Client Phone Number: _____

I, _____ authorize Liz Marso, RD, LD
(name of client/guardian)

to obtain information, and/or release information, as specified to the following person (please √)

Name: _____

Address: _____

Telephone #: _____

Email: _____

Fax #: _____

Purpose of this Request: _____

Specific Information Authorized:

- Lab Values/Medical Test Results
- Medical Records
- Dietary Information
- General Collaboration
- Other: _____

Signed: _____ Date: _____

(Signature of client or guardian)



Financial Agreement and Cancellation Policy

Financial Agreement

Payment for services is due at the time of the appointment, unless other arrangements have been made in advance. I am not a provider for any insurance companies however I will be happy to provide a receipt of payment which may be submitted to your insurance carrier for reimbursement. The insurance carrier may or may not reimburse for the services provided. It is the client's responsibility to collect reimbursement for the services from the insurance carrier.

I accept credit/debit cards (Visa, Master Card or American Express), check or cash. If a check is not provided at the time of service, I will charge the credit/debit card listed on the Debit/Credit Card Release form. **Please make checks payable to Evolve Nutrition and Wellness, LLC.**

Fees for Services:

- Nutrition Counseling, Initial Assessment\$110.00
- Nutrition Counseling, Follow-up\$75.00
- Nutrition Counseling, Packages and Plans Available

Cancellation Policy

No charge for any cancellations greater than 48 hours ahead of time. The full fee will be charged for no-shows or cancellations within 48 hours of the appointment time.

I, _____ agree to the above defined financial and cancellation policies for Evolve Nutrition and Wellness, LLC. In the case of default of payment, I am responsible for full payment of the balance, any collection costs or legal fees incurred to collect on this account. I have read, understand, and accept the information and conditions specified in this agreement.

Client/Guardian Signature

Date



Informed Consent for Nutrition Services

Welcome! Thank you for choosing Evolve Nutrition and Wellness, LLC for your nutrition services. This document contains detailed information regarding your rights and responsibilities and my business policies. Please read it carefully.

Counseling Process and Your Rights Regarding Treatment: I am voluntarily engaging in the counseling services provided by Evolve Nutrition and Wellness, LLC to obtain information and guidance about health factors within my own control (diet, nutrition, and related behaviors) in order to enhance and support my health and wellness.

I understand that Liz Marso, RD, LD is a Registered and Licensed Dietitian and Nutritionist and does not dispense medical advice nor prescribe treatment. Rather, she provides education to enhance my knowledge of health and nutrition as it relates to food, dietary supplements, and behaviors associated with eating. While nutrition support can be an important complement to my medical care, I understand that nutrition counseling is not a substitute for the diagnosis, treatment, and care of a disease by a medical provider. This evaluation and education is intended as a guide to developing an appropriate nutrition care plan for me, and to monitor my progress in achieving my goals. I understand that Liz and I will work together to define my goals for nutrition counseling. Since nutrition counseling is not an exact science, I understand that the results of counseling can be variable. I understand that the attainment of a positive outcome is dependent upon the effort expended by both myself and Liz and I am willing to work as a team in this experience.

I understand that I have the right to ask questions about my care. I have a right to choose a Registered Dietitian who best suits my needs and purposes. I also have the right to end my counseling at any time and understand that I should notify Liz when I am finished. If I decide that I would like to continue my nutrition care with another professional, Liz can help facilitate that process. I understand that Liz reserves the right to refer me to another professional, if the level of care provided by Liz is assessed to be an inappropriate level of care.

I understand that Liz Marso, RD, LD/Evolve Nutrition and Wellness, LLC has the right to terminate nutrition counseling services, if written notification is provided to the client 30 days in advance of the final appointment. This will include a listing of referrals for continuity of care.

I agree to hold Liz Marso, LD, LD/Evolve Nutrition and Wellness, LLC harmless for any and all claims, or damages, in connection with our work together and also release same of all potential liability.

Contacting Liz: I understand that Liz checks email and confidential voicemail daily but does not guarantee an immediate response and makes every effort to return emails & calls within 48 business hours. I also understand that Liz will not offer nutrition counseling over email, but rather uses email communication mainly for scheduling purposes and short responses before or after a counseling session.

Appointments: The scheduling of an appointment involves the reservation of time specifically for each client. I agree to make every effort to keep all scheduled appointments and to be on time. Appointments are virtual or may take place in the office or over the phone. I understand that Evolve Nutrition and Wellness, LLC has a 48-hour cancellation policy. In the event I fail to give a full 48-hour notice of a cancellation via email or phone, I am aware that I will be charged a cancellation fee equal to the cost of the session. Initial appointments are scheduled for 60 minutes. Generally, follow-up sessions are 30 minutes or 50 minutes in duration. Session frequency and follow up duration will vary among individuals and the goals being targeted.

Professional Fees and Financial Agreement: Fees vary depending on type and length of service provided. Please refer to the Financial Agreement and Cancellation Policy for details. There are no refunds for sessions that have transpired.

Please sign this page and bring it to your first appointment.

**** Please sign below to indicate you have read and understand the above notifications and agree to the terms. This signature also indicates that you are consenting to receive Nutrition Counseling services from Liz Marso RD, LD/Evolve Nutrition and Wellness, LLC****

Client Signature

Date

Parent/Guardian Signature

Date



Health Insurance Portability and Accountability Act (HIPAA)

This form describes how protected health information about you may be used and disclosed and how you can get access to this information.

Confidentiality: With the exception of special situations described below, I understand that sessions with Liz are completely confidential. Nothing will be released or disclosed to anyone, unless I provide written authorization. I understand there are limits to my confidentiality, including the following:

- Where there is the risk of imminent harm to myself or another person, Liz has the legal and/or ethical duty to take the appropriate steps to protect life.
- When a court orders Liz to release information, Liz is bound by law to comply.
- In response to a subpoena from a court of a law or a secretary

I understand that Liz will keep brief session notes as a record of our work together. These notes document the topics discussed, interventions used and any other considerations that may be helpful to our work together. The records are maintained in a secure location. Evolve Nutrition and Wellness, LLC will keep your records for three years after the last contact, after which time information will be securely disposed of.

I. Pledge to Protect Health Information

I, owner of Evolve Nutrition and Wellness, LLC understand that protected health information about you and your health is personal. I am committed to protecting health information about you. This Notice applies to all of the records of your care generated by Evolve Nutrition and Wellness, LLC.

This Notice will tell you about the ways in which I may use and disclose protected health information about you. I also describe your rights and certain obligations I have regarding the use and disclosure of protected health information. The law requires me to:

- make sure that protected health information that identifies you is kept private;
- notify you about how I protect protected health information about you;
- explain how, when and why I use and disclose protected health information;
- follow the terms of the Notice that is currently in effect.

I am required to follow the procedures in this Notice. I reserve the right to change the terms of this Notice and to make new notice provisions effective for all protected health information that I maintain by: making copies of the revised Notice available upon request.

II. How I may use or disclose protected health information about you:

- **Treatment:** Coordinate and/or manage your care with treatment team in the event you undergo treatment.
- **Payment:** In the event you submit nutrition services to insurance for reimbursement.
- **As Required By Law:** Disclose protected health information about you when required by federal, state or local law.
- **Health Risk:** If I believe you are a victim of abuse, neglect or domestic violence.

- **Business Associates:** I may disclose information to associates that perform services on my behalf (lawyers, accountants) but require them to safeguard your information.
- **Public Health:** Preventing a controlled disease.
- **Law Enforcement:** Respond to warrant of a court, subpoena, and administrative request.
- **Coroners, Medical Examiners, Funeral Directors:** To determine cause of death.
- **Food and Drug Administration:** Reporting adverse effects of food, supplements, products.

III. You can object to certain uses and disclosures.

Unless you object, or request that only a limited amount or type of information be shared, I may use or disclose protected health information about you in the following circumstances:

I may share with a family member, relative, friend or other person identified by you, protected health information directly relevant to that person's involvement in your care or payment for your care. I may also share information to notify these individuals of your location and general condition.

IV. Your rights regarding protected health information about you:

You have the following rights regarding protected health information I maintain about you:

Right to Inspect and Copy: You have the right to inspect and copy protected health information that may be used to make decisions about your care. To inspect and copy protected health information that may be used to make decisions about you, you must submit your request in writing to Evolve Nutrition and Wellness, LLC. If you request a copy of the information, I may charge a fee for the costs of copying, mailing or other supplies associated with your request, and I will respond to your request no later than 30 days after receiving it.

Right to Amend: If you feel that protected health information I have about you is incorrect or incomplete, you may ask me to amend or supplement the information. To request an amendment, your request must be made in writing and submitted to Evolve Nutrition and Wellness, LLC. In addition, you must provide a reason that supports your request. I will act on your request for an amendment no later than 60 days after receiving the request.

I may deny your request for an amendment if it is not in writing or does not include a reason to support the request and I will provide a written denial to you. In addition, I may deny your request if you ask me to amend information that:

- Was not created by me, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the protected health information kept by Evolve Nutrition and Wellness, LLC.
- Is not part of the information which you would be permitted to inspect and copy; or
- I believe is accurate and complete.

Right to Request Confidential Communications: You have the right to request that I communicate with you about health matters in a certain way or at a certain location. For example, you can ask that I only contact you at work or by email.

VI. You may file a complaint about my privacy practices.

If you believe your privacy rights have been violated, you may file a complaint with Evolve Nutrition and Wellness, LLC or file a written complaint with the Secretary of the Department of Health and Human Services. A complaint to the Secretary should be filed within 180 days of the occurrence or action that is the subject of the complaint. If you file a complaint, I will not take any action against you or change the care and services I provide.



Health Insurance Portability and Accountability Act (HIPAA)

Acknowledgement of Receipt of Notice of Privacy Practices

Please sign this page and bring it to your first appointment. Thank you.

I, _____, have received a copy of *Evolve Nutrition and Wellness, LLC* HIPAA Privacy Practices.

Client Name (print): _____

Client Signature: _____

Guardian/Parent Signature: _____

Date: _____

It is your right to refuse to sign this document.



Communication Agreement

Should I, _____ (name) decide to use an email system, fax and/or text message to contact my dietitian, I understand and accept the following terms:

1. My dietitian is the only person using the computer, phone, and email system. However, complete privacy cannot be guaranteed due to the state of computer technology.
2. Given that email or text messages might be generated from, or to, your home, office, or public place there is no way to guarantee the confidentiality of the email or text at that end of the communication.
3. The system used by my dietitian is not equipped with encryption or firewalls, etc. However, the email and phone system is not used by any other person.

Preferred mode of communication (please check) _____ Phone _____ Email

Phone number (preferred): _____ Circle one: work home cell

Please check () to indicate if I may communicate with you via **text message**: _____ No _____ Yes

Please check () if a **voice mail** may be left on the following phone numbers

_____ Home Phone _____ Cell Phone _____ Work Phone _____ None

Email Address: _____ Please check () to indicate whether or not I may communicate with you via email: _____ No _____ Yes

Client/Guardian Name (please print): _____

Client/Guardian Signature: _____ Date: _____

Dietitian Signature: _____ Date: _____