Julie Hayes-Nadler, RDN, IFNCP
www.jhnnutrition.com
805-448-8461

Patient Name _____

Address _____

_____

Date of Birth _____

Cell _____ Email _____

Person responsible for payment for services_____

Parent Phone and email (for minors)_____

Preferred Payment : Zelle_____ PayPal _____

Name/Email/phone associated with PayPal or Zelle account

_____

_____

Payment and Cancellation Policy:

1. For non-insurance, cash pay clients, electronic payment is required on the same day of service unless special arrangements are agreed upon in advance. We will send a payment request via Zelle or PayPal. If you are seeking insurance reimbursement, we can provide a statement for paid sessions to submit to insurance once a month upon request.
2. For non-insurance clients, my initial assessment fee is $195 and follow up consultation fees are $175 for 50 min sessions. Please note that the initial session is primarily about history taking and assessment of your current challenges. Although I will be able to give you an overview of how we will work together to reach your goals and will have time to answer questions, a nutrition plan will not be implemented until our first follow up session.
3. Please make cancellations 24 hours in advance. Sessions cancelled with less than a 24-hour notice will require full payment.
4. Santa Barbara Select IPA patients will receive an authorization for your sessions before we meet for our initial assessment. If there is a copay due for your policy your insurance

authorization will let us know what that is and I will send a zelle or paypal request on day of service. Feel free to ask me in advance if your insurance has stated that you will have a copayment for my services.

5. For patients who carry Santa Barbara Select IPA insurance, I will be able to tell you once I receive the authorization from your physician how many sessions have been approved. Please note that missed sessions or cancellations without 24-hour notice will not be paid for by your insurance so you as the client are responsible for payment out of pocket.
6. For parents of young adults who have agreed to pay for their child's sessions:
   I understand that I am responsible for payment for my child's sessions with Julie Hayes-Nadler, RDN. I understand that any appointment missed without a 24-hour notice will be billed for and I agree to pay.

   I understand and agree to the above payment and cancellation policy.

   Signature:_____ Date_____

I give Julie Hayes-Nadler, RDN permission to communicate with the following professionals/parents about my case.

1._____ Phone_____

2._____ Phone_____

3._____ Phone_____

I hereby release Julie Hayes-Nadler, RD from any liability or legal responsibility in connection with the release of this information. I understand the risks of faxing and emailing medical information. I understand that I may revoke this consent in writing at any time, except to the extent that action has already been taken in response to this authorization. I understand that the potential for information disclosed pursuant to this authorization is subject to re-disclosure by the recipient other than Julie Hayes-Nadler, which would be beyond the control of Julie Hayes-Nadler and may no longer be protected by federal law. I request that all pertinent information regarding my case be released.

Patient Signature _____ Date _____

Regular unencrypted phone, text and email communication is not considered secure. I understand this and recognize any text, email or phone communication I have with Julie Hayes-Nadler using our phones or email is not encrypted and therefore could potentially be compromised. I give Julie Hayes-Nadler permission to communicate with me and my professional care team listed above using unencrypted phone, text or email.

Patient Signature _____ Date _____

HIPPA Guidelines

Description of Privacy Practices

I am dedicated to protecting your privacy. Below is a description of how I will maintain the confidentiality of your health records. My practices meet the requirements of federal and state privacy laws. I will not let anyone have access to your records or give anyone information without your written consent. If however you have agreed that I am to bill your insurance company for nutrition services your signature below indicates your permission for me to discuss diagnosis, progress, and dates of services with representatives of your insurance company. If your account becomes past due your signature below gives me permission to discuss dates of service and contact information with a collection agency representative. I am hereby asking permission to share certain information with other healthcare providers involved in your treatment. I may consult with other clinicians in the role of consultants about your case. In this situation I will disguise your identity. Unless instructed otherwise there will be times that I may have to respond to you via e-mail, text, phone, fax. It is important for you to realize that these messages could be inadvertently received or overheard by an unintended third party.

I can be reached at 805-448-8461 during office hours. I check voice mail and text and email regularly but if you should experience a life-threatening emergency, you should call 911 or go to your nearest emergency room.

In addition, I will abide by state and federal laws that allow disclosures of health information to improve treatment, to receive payment for services. These laws also require that patients receive a written notice of the healthcare provider's privacy practices (this document). Patients may ask for further restrictions on the ways in which I use and disclose information. I am not required by law to agree to further restrictions. I will agree unless I am unable to do so. Patients may ask (in writing) that I communicate with them at a different address or use a different means of communication. I will make every effort to accommodate such requests. Patients may see or request a copy of their nutrition records or any other health information that I keep on file. I may charge a reasonable fee for copies. Patients must ask in writing for any amendments to their records. I must decide whether an amendment is warranted but the request and explanation of the amendment will be kept in their file. Patients may request (in writing) a written account of disclosures I have made of their health records. Patients may designate a "Personal Representative" to help them exercise their privacy rights. Patients have the right to agree or object to family and friends being involved in their care. State laws require that suspected child abuse or neglect, or suspected child abuse or neglect or exploitation of a vulnerable adult must be reported.

If you believe your privacy rights have been violated, you may complain to me and The Secretary, US Department of Health and Human Services, Washington DC 20201. If you have any questions about my privacy practices or confidentiality, please bring them to my attention.

Your signature below reflects that you have read and understand this statement of Privacy Practices. If you have any questions, you will discuss them with Julie Hayes-Nadler, RD.

Signature_____ Date _____

INFORMED CONSENT FORM & TERMS FOR NUTRITION COUNSELING

I am employing the counseling services of Julie Hayes-Nadler, RDN, IFNCP so that I can obtain information and guidance about health factors within my own control (diet, nutrition, and related behaviors) in order to nourish and support my or my child's health and wellness.

I understand that Julie Hayes-Nadler, RDN, IFNCP is a Registered Dietitian/Nutritionist and Nutrition/Health Educator and does not dispense medical advice nor prescribe treatment. Rather, she provides education to enhance my knowledge of health as it relates to food, lifestyle, exercise, dietary supplements, and behaviors associated with eating. While nutrition and botanical support can be an important complement to my medical care, I understand nutrition counseling is not a substitute for the diagnosis, treatment, or care of disease by a medical provider.

Nutrition evaluation or testing that is recommended and I choose to utilize 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 (or my child), and/or to monitor progress in achieving my goals for myself or my child.

I understand that Julie Hayes-Nadler, RDN, IFNCP will keep progress 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 in our work together.

Medical records, personal information and history divulged in session to Julie Hayes-Nadler, RDN, IFNCP will be kept strictly confidential unless I consent to sharing my medical and nutrition related information by way of a signed release.

I have read the HIPPA form included in my registration packet and I agree to hold Julie Hayes-Nadler, RDN, ICFNP harmless for claims or damages in connection with her work with me or my child. This is a contract between myself and Julie Hayes-Nadler, RDN, ICNCP, and I understand that it is also a release of potential liability.

Nutrition counseling services may be terminated at the discretion of Julie Hayes-Nadler, RDN, IFNCP if written notification is provided to me 30 days in advance of final appointment. This will include a listing of referrals for continuity of care.

Client or Guardian's Signature _ Date _____