

REGISTRATION AND CONSENT FORM

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Welcome ! I am glad to have the opportunity to meet you.

Below you will find a lot of detailed information regarding your rights and responsibilities and established policies of Julie Church's nutrition counseling practice. Please read this carefully and sign at the bottom, if agree. Please feel free to ask Julie any needed questions or clarifications.

Appointments:

I agree to make every effort to keep all schedule appointments and be on time. If I cannot attend a scheduled session, I will call Julie Church to cancel and/or reschedule. There will be no fee if phone message or conversation is received before 24 hours of the scheduled appointment time. If phone message or conversation is received after the 24 hour time frame full fee will be responsible to be paid to Julie Church for that cancelled or missed session. (Please note that if insurance is being used for payment, Julie cannot bill insurance for a no-show/late cancellation and therefore the client is responsible for the full fee).

Initial appointments and follow up appointments will last 50 minutes. Occasional 30 minute follow up appointments are available, when appropriate.

I have been informed that Julie Church has the right to terminate services offered with a 30 day written notification given to the client with a listing of referrals for continuity of care.

Confidentiality:

I understand that no information about my treatment will be released to anyone unless I provide written authorization. The only exception to this would be if I have not paid for services and are sent to collections for payment; then necessary information will be released in order for Julie to get paid for service. I also understand that there are limits to my confidentiality, including the following:

- Where there is the risk of imminent harm to myself or another person, Julie has the legal and/or ethical duty to take the appropriate steps to protect life.
- When a court orders Julie to release information, Julie is bound by law to comply.
- When Julie has reason to believe that child or an elderly person is in danger of or is being abused (physically, emotionally, or sexually), Julie is obligated by law to report the abuse.
- In response to a subpoena from a court of a law or a secretary

Email:

I understand that email may not be a confidential method of communication and understand that phone or in-person contact is the best way to communicate personal information. I understand that Julie Church usually checks email everyday but does not guarantee immediate response to email contact. I also understand that there are instances where e-mails are sent but never received. For these reasons, phone or in-session contact is the preferred method to ensure a timely response. I also understand that Julie will not offer nutrition counseling over email, but rather uses email communication mainly for scheduling purposes.

Fees and Financial Agreement:

Julie Church's fees are: 50 minute initial session = \$125.00
50 minute follow-up session = \$110.00

Fees for service are due at the time the service is provided. Cancellation policy is outlined above. Forms of payment accepted include: cash, check, and credit card.

If I have Regence or Aetna insurance, Julie will bill to the insurance company directly. Please provide your insurance card to Julie for copying and complete the insurance information on the attached page.

Nutrition counseling services are very often covered by other insurance companies as an out-of-network benefit, but if I choose to attempt reimbursement from my insurance company for Julie's services all the billing is my responsibility. Julie will provide for me a "super" receipt once a month that can be submitted to my insurance company by myself for possible reimbursement. I have the responsibility to research this possibility at my desired time. I understand Julie is not guaranteeing any reimbursement but rather is suggesting this is a possibility and is willing to help me expedite that possibility.

I also understand that phone conversations lasting more than 15 minutes will be billed at the cost of \$25 per additional 15 minutes, for example a conversation between 15 and 30 minutes will be \$25 and a conversation between 30 and 45 minutes will be \$50. Phone conversations are not covered by any insurance plan. Payment for these phone consults will be an out-of-pocket expense.

Emergency Contact/Crises:

I understand that Julie Church is not on call 24 hours a day. I understand that I am free to call Julie at her phone number during off hours and leave a phone message. In cases of emergency when immediate help and counsel is needed I understand the local resources available are:

- Seattle Crisis Clinic: 1-866-4CRISIS
- Emergencies: 911

Counseling Process and Your Rights Regarding Treatment:

I understand that Julie 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 Julie and I am willing to put my part into this experience.

I understand that I have the right to ask questions about my counseling. I have a right to choose a 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 Julie when I am finished. If I decide that I would like to continue my nutrition counseling with another professional, Julie Church can facilitate that process. I understand that Julie Church reserves the right to refer me to another professional if the level of care provided by Julie is assessed by Julie to not be the appropriate level of care.

Washington State Law:

I understand that if I have concerns about my treatment I can talk directly with Julie about these issues. I also understand that if I want more information about the law regulating counselors or want to file a complaint I can write to: Department of Health, Health Professions Quality Assurance, PO Box 47869, Olympia, Washington, 98504 or call (360) 236-4700. I have been given Julie Church's disclosure statement.

Instructions for completion: ALL new clients please complete the first two boxes. If the client is a dependent, parents, please complete the third box. If paying by credit card or using Regence insurance please complete the bottom half

Consent for Treatment

I have read through all the above information and have been clearly advised of my rights and responsibilities as a client of Julie Church. I understand these rights and responsibilities and agree to abide by them. I consent to treatment, and I understand I have a right to receive a copy of this form upon request. I also understand that I can withdraw this consent in writing and terminate at any time.

Client Name (please print) _____

Signature_____ Date_____

General Information

Client Name: _____ Birthdate: _____

Mailing Address: _____

Phone Number: _____ May I call you here? (Y/N) May I leave you a message here ? (Y/N)

Email: _____

Child and Adolescent Consent for Treatment (if applicable)

Client Name (please print)_____ Birthdate_____

I certify that I am the (check one) ___father, ___mother, ___legal guardian of the above named child/adolescent and that I do have legal custody of the above named child/adolescent. I, hereby, give my authorization and consent for the above named child/adolescent to receive nutrition counseling from Julie Church, RD, CD.

Parent or Legal Guardian Name (please print) _____

Signature_____

Date_____

Payment Methods (cash and check are always welcome):

1. Credit Card payments (complete only if you are paying with credit card):

If I choose my method of payment to be credit card for regular services Julie can manually enter the information or swipe the card in the appointment.

Credit Card information (required): Credit card type (circle one): Visa Mastercard Discover

Card number: _____ - _____ - _____ - _____

Expiration date: _____ / _____ CVC number (3 digit code on back of card): _____

If credit card is the primary method of payment I understand a nonrefundable fee will be charged for any cancellation/no show less than 24 hours and for outstanding balances, including claims denied by insurance.

Cardholder's signature: _____

2. Insurance: (complete only if you are using Regence or Aetna insurance for visits)

Name of Insurance Plan: _____

Name of Insured: _____ Date of Birth of Insured: _____

Address of Insured: _____

Insured ID Number: _____ Group ID: _____

Name of Insureds Employer: _____

Phone Number of Insured: _____ Co-pays: _____