Libby Hugo, RDN
NUTRITION COUNSELING

1110 W. Ironwood Dr.
Coeur d'Alene, ID 83814
Phone: (208) 640-4502
Fax: (208) 765-5070
Email: nutrition@libbyhugo-rdn.com

Patient Information

Patient name (Last, First, MI): _____ Date of birth: _____

Mailing Address: _____ City: _____ State: ___ Zip: _____

Home phone: _____ May I contact you / leave message at home? YES NO

Work phone: _____ May I contact you / leave message at work? YES NO

Cell Phone: _____ May I contact you / leave message on your cell? YES NO

Email Address: _____ Preferred Method of Contact: CELL or EMAIL

Social Security # (required to bill insurance): _____ Age: _____ Employer: _____

Occupation: _____

Person responsible for account (if other than client): _____

Relationship of above person to client: _____

Address: _____City: _____ State: _____ Zip: _____

Telephone: Home: _____ Work: _____ Cell: _____

Insurance (I will need a copy of your card if we're billing your insurance): _____

****

Primary physician name: _____ Phone: _____

Current diagnoses: _____

_____

Current medications: _____

_____

How were you referred? ❒ Physician ❒ Friend ❒ Internet ❒ Other

What is your primary concern/reason for seeing a dietitian?_____

_____

_____

Libby Hugo, RDN
NUTRITION COUNSELING

1110 W. Ironwood Dr.
Coeur d'Alene, ID 83814
Phone: (208) 640-4502
Fax: (208) 765-5070
Email: nutrition@libbyhugo-rdn.com

Office Guidelines and Policies

Welcome, and thank you for choosing me as your Registered Dietitian Nutritionist. I look forward to helping you achieve the goals which motivated you to find me. The guidelines below have been established to facilitate our work together.

Confidentiality

Our sessions are held in strict confidence. A release form will be used to obtain permission to communicate with your physician or other health care professionals as well as friends or family members if you choose.

Liability

Although sessions take place within Dr. Schmitt's office, the doctor is not liable for nor does he assume any of your care if you are not already a patient of his.

Payment policy

Payment is required at the time of your session, unless insurance is being billed or prior arrangements have been made.
Cash, personal checks, and credit/debit cards are accepted (including flexible spending cards)—this office accepts Visa or Mastercard. If someone other than the client will be paying for the appointment, such as a parent paying for a child's appointment, check or cash must be brought to the appointment, or a credit card number kept on file and charged at the appointment time.

Insurance billing

Several insurance companies cover medical nutrition therapy (MNT) as a benefit—MNT is often also referred to as nutrition or diet counseling. **You are advised to contact your insurance company to find out if your particular health insurance plan includes MNT as a covered benefit.** You may have a deductible to meet before particular services are covered; your insurance plan may include a coinsurance amount or a copay; and/or your plan may specify MNT benefits under preventive, in which case you should inform me so that I may bill for your visit correctly. If your insurance carrier does not pay, you are responsible for payment—this includes the difference of the total cost or the total cost in full.

Fee schedule

Call for current self-pay/cash rates—by law, these are comparable to current allowable insurance charges. I will gladly bill any and all insurance carriers with which I am contracted; if I am not contracted with your insurance carrier or nutrition counseling is not a covered benefit by your insurance carrier, you will be billed the allowed amount determined by your insurance carrier. Cash price is only honored if paid in full at the time of service; this fee schedule also applies to scheduled telehealth (via phone or internet) consultations.

Cancellations

24-hour notice, *via telephone*, is required for all cancellations (72 hours for Monday appointments)—my availability via telephone is Monday-Thursday 9:00am-3:00pm and Friday 9:00am-11:30am. With such notice, I am able to schedule someone else in your time slot. Appointments missed or canceled without appropriate notice (no-call/no-shows) will be charged $50.00—this charge is not billable to insurance.

Telephone calls and email correspondence between visits

I am available to assist you by phone for a few minutes if you need to speak with me between sessions and I also respond to emails when I have time. Leave me a message with your phone number and I will return your call as soon as possible. If you need more than a few minutes on the phone, please consider scheduling an appointment to sit and meet with me. Unfortunately, I don't have the flexibility to spend more than a few minutes at a time on the phone.

Cell phones and pagers

So that I may give you the time and attention you deserve, please turn off cell phones during our session.

Your signature indicates that you have read, understand, and agree to the above policies. Please feel free to ask any questions; my goal is to meet your needs and provide you with optimal nutrition care.

_____ _____ _____

SIGNATURE (client, client's representative, or parent) **PRINT NAME** (client, client's representative, or parent) **DATE**

Libby Hugo, RDN
NUTRITION COUNSELING

1110 W. Ironwood Dr.
Coeur d'Alene, ID 83814
Phone: (208) 640-4502
Fax: (208) 765-5070
Email: nutrition@libbyhugo-rdn.com

Patient Authorization for Use/Disclosure of Protected Health Information

This form allows me to communicate with members or your health care team (physician, therapist, etc.) and/or friends or family members.

Client name (print):_____

I request and authorize Libby Hugo, RDN to share (release and obtain from) health care information, both verbal and written, of the client named above with:

Name: _____
(name of individual or entity to receive or contribute information)

Address: _____

Telephone: _____ Fax: _____

Name: _____
(name of individual or entity to receive or contribute information)

Address: _____

Telephone: _____ Fax: _____

Name: _____
(name of individual or entity to receive or contribute information)

Address: _____

Telephone: _____ Fax: _____

This authorization expires either one year from the date listed below or when the above named client or personal representative revokes this authorization in writing. I understand that I have the right to revoke this authorization at any time. However, my revocation will not have any effect on any actions Libby Hugo, RDN took before she received the revocation. I understand that once Libby Hugo, RDN releases the information, the information may be subject to re-disclosure by the party receiving the information and may no longer be protected by federal or state law.

_____ _____
Signature of client, client's representative, or parent Date

_____
Printed name of client, client's representative, or parent