Anders & Dunaway Nutrition Consultants, Inc.

PATIENT INFORMATION

Last Name: _____ **First Name:** _____ **Middle Initial:** ___

Address: _____**Apt. #**_____

City: _____**State:**_____**Zip:**_____

Home Phone: ( ) _____ **Cell Phone: ( )** _____

Social Security #:_____ **Email:**_____

Age: _____ **Date of Birth:** _____ **Sex: (please circle) Male Female**

Are You Employed: (please circle) Yes No Your Occupation: _____

Place of Employment: _____ **Work Phone # ( )** _____

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

Marital Status: (please circle) Single Married Divorced Widowed

Spouse/Guardian Last Name: _____ **First:** _____ **Middle Initial:** ____

Spouse/Guardian Date of Birth: _____

Address: _____**Apt. #:**_____

City: _____**State:**_____**Zip:**_____

Home Phone: ( ) _____**Guardian/Spouse Social Security #:**_____

Spouse/Guardian Employer: _____ **Work Phone ( )** _____

Emergency Contact: _____ **Relationship:** _____

Phone: _____

Sign: _____ **Date:** _____

Anders & Dunaway Nutrition Consultants, Inc.

2121 E. Flamingo Rd. #110, Las Vegas, NV 89119
702-382-8841

Client Financial Responsibility Form

Client Name: _____

We ask that all patient read and sign our Financial Policy as well as complete our Patient Information form prior to your Nutrition Counseling Session.

Cash Patients – payment for services are due at the time services are rendered. No exceptions. We accept cash, checks, Master Card and Visa.

Returned checks – will be subject to a $25.00 fee for processing.

Insured Patients – must have insurance cards, and/or insurance forms. All co-pays and deductibles are due at the time services are rendered. No exceptions. Please note that any claim denied by the insurance company becomes the patient's responsibility.

Delinquent accounts will be turned over to an attorney or collection agency without notice. Accounts will be considered delinquent if unpaid within 60 days. In the event your account is turned over for collection, you will be responsible for all reasonable collection and court costs up to 50% of the outstanding balance at the time the account is considered delinquent.

Patient Signature: _____ **Date:** _____

- **Cancellation or Reschedule Policy**

Patients are required to provide at least 24- hour notification if an appointment needs to be rescheduled or cancelled. A "No-Call, No-Show" appointment will be subject to a $25 Cancellation fee.

Patient Signature: _____ **Date:** _____

- **Patient Written Acknowledgement Confirming Receipt of Privacy Notice**

I have received Anders & Dunaway Nutrition Consultants Inc. HIPAA Privacy Notice.

Patient Signature: _____ **Date:** _____

Anders & Dunaway Nutrition Consultants, Inc.

INSURANCE INFORMATION

YOU MUST HAVE THE FOLLOWING:
(PICTURE ID, INSURANCE CARDS, ANOTHER ID)

Please complete the following based on the insurance company that is responsible for your claim.

Primary Insurance: _____ Address: _____

City: _____ State: _____ Zip: _____

Insured's Name: _____ Insured's Date of Birth: _____

ID#: _____ SS#: _____ Group#: _____

Effective Date: _____

Secondary Insurance: _____ Address: _____

City: _____ State: _____ Zip: _____

Insured's Name: _____ Insured's Date of Birth: _____

ID#: _____ SS#: _____ Group#: _____

Effective Date: _____

Assignment and Release:

I hereby authorize payment be made directly to Anders & Dunaway Nutrition Consultants Inc. for professional services rendered and I shall be personally responsible for any unpaid balance to Anders & Dunaway Nutrition Consultants Inc. I understand the filing of insurance claims is a courtesy and that I am responsible for all charges from the date services are rendered. I understand that all co-pays and deductibles are due and payable at the time of services. I hereby authorize the doctor to release all information including medical records necessary to secure the payment of benefits. I authorize the use of the signature on all insurance submissions.

_____

Patient/Guardian Signature Date

Medicare Authorization:

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Anders & Dunaway Nutrition Consultants Inc. for any services furnished to me by Anders & Dunaway Nutrition Consultants Inc. I authorize any holder of medical information about me to release to the Health Care Finance Administration and its agents any information needed to determine these benefits payable for related services. I understand in Item 9 of the HCFA 1500 form or elsewhere on the other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown in Medicare assigned cases, Anders & Dunaway Nutrition Consultants Inc. or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible only for the deductible, co-insurance, and non-covered services. Co-insurances and deductibles are based on the charge determination of the Medicare Carrier.

_____

Patient/Guardian Signature Date

Medical Information Release Form

(HIPAA Release Form)

Name: _____ **Date of Birth:** ____/____/_____

Release of Information

[ ] I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This information may be released to:

[ ] Spouse_____

[ ] Child(ren)_____

[ ] Other_____

[ ] Information is not to be released to anyone.

This ***Release of Information*** will remain in effect until terminated by me in writing.

Messages

Please call [ ] my home [ ] my work [ ] my cell Number:_____

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] _____

The best time to reach me is (*day*)_____ between (*time*)_____

Signed: _____ Date: ____/____/_____

Witness:_____ Date: ___/____/_____

A. Notifier: Anders and Dunaway Nutrition Consultants, Inc.

B. Patient Name: **C. Identification Number:**

Advance Beneficiary Notice of Noncoverage (ABN)

NOTE: If Medicare doesn't pay for **D.**_____below, you may have to pay. Medicare does not pay for everything, even some care that you or your health care provider have good reason to think you need. We expect Medicare may not pay for the **D.**_____below.

D.	E. Reason Medicare May Not Pay:	F. Estimated Cost
Medical Nutrition Therapy: ☐ Diabetes ☐ Chronic Kidney Disease	Not a covered service.	Initial consultation $75.00 Follow-up consultation $45.00

WHAT YOU NEED TO DO NOW:

- Read this notice, so you can make an informed decision about your care.
- Ask us any questions that you may have after you finish reading.
- Choose an option below about whether to receive the **D.**_____listed above.
  Note: If you choose Option 1 or 2, we may help you to use any other insurance that you might have, but Medicare cannot require us to do this.

G. OPTIONS: Check only one box. We cannot choose a box for you.

☐ **OPTION 1.** I want the **D.**_____listed above. You may ask to be paid now, but I also want Medicare billed for an official decision on payment, which is sent to me on a Medicare Summary Notice (MSN). I understand that if Medicare doesn't pay, I am responsible for payment, but **I can appeal to Medicare** by following the directions on the MSN. If Medicare does pay, you will refund any payments I made to you, less co-pays or deductibles.

☐ **OPTION 2.** I want the **D.**_____listed above, but do not bill Medicare. You may ask to be paid now as I am responsible for payment. **I cannot appeal if Medicare is not billed.**

☐ **OPTION 3.** I don't want the **D.**_____listed above. I understand with this choice I am **not** responsible for payment, and **I cannot appeal to see if Medicare would pay.**

H. Additional Information:

This notice gives our opinion, not an official Medicare decision. If you have other questions on this notice or Medicare billing, call **1-800-MEDICARE** (1-800-633-4227/**TTY:** 1-877-486-2048). Signing below means that you have received and understand this notice. You also receive a copy.

I. Signature:	J. Date:

CMS does not discriminate in its programs and activities. To request this publication in an alternative format, please call: 1-800-MEDICARE or email: AltFormatRequest@cms.hhs.gov.

HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.
If you have any questions about this notice, please contact:

Anders & Dunaway Nutrition Consultants Inc.

(702) 382-8841 2121 E. Flamingo Rd., #110 Las Vegas, NV 89119

OUR PLEDGE REGARDING PROTECTED HEALTH INFORMATION:
We at Nutrition Consultants Inc. understand that protected health information about you and your health is personal. We are committed to protecting health information about you. This Notice applies to all of the records of your care generated by Nutrition Consultants Inc, whether made by at Nutrition Consultants Inc. personnel or your personal doctor.
This Notice will tell you about the ways in which we may use and disclose protected health information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of protected health information. The law requires us to:

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

We are required to follow the procedures in this Notice. We reserve the right to change the terms of this Notice and to make new notice provisions effective for all protected health information that we maintain by:

- posting the revised Notice in our office
- making copies of the revised Notice available upon request;
- posting the revised Notice on our Web site.

HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU.
The following categories describe different ways that we use and disclose protected health information without your written authorization.
For Treatment. We may use protected health information about you to provide you with, coordinate or manage your medical treatment or services. We may disclose protected health information about you to doctors, nurses, technicians, medical students, or other Nutrition Consultants Inc. personnel who are involved in taking care of you.
Nutrition Consultants Inc. staff may also share protected health information about you in order to coordinate the different things you need, such as prescriptions, lab work and x-rays. We also may disclose protected health information about you to people outside Nutrition Consultants Inc. who may be involved in your medical care, such as clergy or others we use to provide services that are part of your care.
We may use and disclose protected health information to contact you as a reminder that you have an appointment for treatment or medical care at the Nutrition Consultants Inc. We may use and disclose protected health information to tell you about or recommend possible treatment options or alternatives or health-related benefits or services that may be of interest to you.
For Payment for Services. We may use and disclose protected health information about you so that the treatment and services you receive at the Nutrition Consultants Inc. be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about nutrition services you received at Nutrition Consultants Inc. so your health plan will pay us or reimburse you for the service. We may also tell your health plan about the nutrition services you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.
For Health Care Operations. We may use and disclose protected health information about you for Nutrition Consultants Inc. health care operations, such as our quality assessment and improvement activities, case management, coordination of care, business planning, customer services and other activities. These uses and

disclosures are necessary to run the facility, reduce health care costs, and make sure that all of our patients receive quality care.
For example, we may use protected health information to review our treatment and services and to evaluate the performance of the dietitian who is providing your services. We may also combine protected health information about many Nutrition Consultants Inc. patients to decide what additional services the Nutrition Consultants Inc. should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, and other Nutrition Consultants Inc. personnel for review and learning purposes. We may also combine the protected health information we have with protected health information from other health care facilities to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of protected health information so others may use it to study health care and health care delivery without learning who the specific patients are. We may also contact you as part of a fundraising effort.
Subject to applicable state law, in some limited situations the law allows or requires us to use or disclose your health information for purposes beyond treatment, payment, and operations. However, some of the disclosures set forth below may never occur at our facilities.
As Required By Law. We will disclose protected health information about you when required to do so by federal, state or local law.
Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information
Health Risks. We may disclose protected health information about you to a government authority if we reasonably believe you are a victim of abuse, neglect or domestic violence. We will only disclose this type of information to the extent required by law, if you agree to the disclosure, or if the disclosure is allowed by law and we believe it is necessary to prevent or lessen a serious and imminent threat to you or another person.
Judicial and Administrative Proceedings. If you are involved in a lawsuit or dispute, we may disclose your information in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made, either by the requesting party, or us to tell you about the request or to obtain an order protecting the information requested.
Business Associates. We may disclose information to business associates who perform services on our behalf (such as billing companies;) however, we require them to appropriately safeguard your information.

Public Health. As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

To Avert a Serious Threat to Health or Safety. We may use and disclose protected health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
Health Oversight Activities. We may disclose protected health information to a health oversight agency for activities authorized by law. These activities include audits, investigations, and inspections, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.
Law Enforcement. We may release protected health information as required by law, or in response to an order or warrant of a court, a subpoena, or an administrative request. We may also disclose protected health information in response to a request related to identification or location of an individual, victims of crime, decedents, or a crime on the premises.
Organ and Tissue Donation. If you are an organ donor, we may release protected health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
Special Government Functions. If you are a member of the armed forces, we may release protected health information about you if it relates to military and veterans activities. We may also release your protected health information for national security and intelligence purposes, protective services for the President, and medical suitability or determinations of the Department of State.

Coroners, Medical Examiners, and Funeral Directors. We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose protected health information to funeral directors consistent with applicable law to enable them to carry out their duties.

Correctional Institutions and Other Law Enforcement Custodial Situations. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release protected health information about you to the correctional institution or law enforcement official as necessary for your or another person's health and safety.

Worker's Compensation. We may disclose information as necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Food and Drug Administration. We may disclose to the FDA, or persons under the jurisdiction of the FDA, protected health information relative to adverse events with respect to drugs, foods, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

YOU CAN OBJECT TO CERTAIN USES AND DISCLOSURES

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

- We 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. We may also share information to notify these individuals of your location, general condition or death.
- We may share information with a public or private agency (such as the American Red Cross) for disaster relief purposes. Even if you object, we may still share this information if necessary for the emergency circumstances.

If you would like to object to use and disclosure of protected health information in these circumstances, please call or write to our contact person listed on page 1 of this Notice.

YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU.

You have the following rights regarding protected health information we 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. Usually, this includes medical and billing records.

To inspect and copy protected health information that may be used to make decisions about you, you must submit your request in writing *to* Nutrition Consultants Inc. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request, and we will respond to your request no later than 30 days after receiving it. There are certain situations in which we are not required to comply with your request. In these circumstances, we will respond to you in writing, stating why we will not grant your request and describe any rights you may have to request a review of our denial.

Right to Amend. If you feel that protected health information we have about you is incorrect or incomplete, you may ask us to amend or supplement the information.

To request an amendment, your request must be made in writing and submitted *to* Nutrition Consultants Inc. In addition, you must provide a reason that supports your request. We will act on the your request for an amendment no later than 60 days after receiving the request.

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

- Was not created by us, 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 Nutrition Consultants Inc.
- Is not part of the information which you would be permitted to inspect and copy; or
- We believe is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of protected health information about you.
To request this list or accounting of disclosures, you must submit your request in writing to Nutrition Consultants Inc. You may ask for disclosures made up to six years before your request (not including disclosures made before April 14, 2003). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We are required to provide a listing of all disclosures except the following:

- For your treatment
- For billing and collection of payment for your treatment
- For health care operations
- Made to or request by you, or that you authorized
- Occurring as a byproduct of permitted use and disclosures
- For national security or intelligence purposes or to correctional institutions or law enforcement regarding inmates
- As part of a limited data set of information that does not contain information identifying you

Right to Request Restrictions. You have the right to request a restriction or limitation on the protected health information we use or disclose about you for treatment, payment or health care operations or to persons involved in your care.
We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment, the disclosure is to the Secretary of the Department of Health and Human Services, or the disclosure is for one of the purposes described on pages 4-5. To request restrictions, you must make your request in writing to Mary Dunaway or Marilyn Anders.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.
To request confidential communications, you must make your request in writing to Mary Dunaway or Marilyn Anders. We will accommodate all reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice at any time by contacting Mary Dunaway or Marilyn Anders.

OTHER USES AND DISCLOSURES
We will obtain your written authorization before using or disclosing your protected health information for purposes other than those provide for above (or as otherwise permitted or required by law). You may revoke this authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your information, except to the extent that we have already taken action in reliance on the authorization.

YOU MAY FILE A COMPLAINT ABOUT OUR PRIVACY PRACTICES
If you believe your privacy rights have been violated, you may file a complaint with the Mary Dunaway or Marilyn Anders 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, we will not take any action against you or change our treatment of you in any way.