Gina Beitmirza, MS, RD, LDN, CND, CLT, CCC Nutrition Policies

Please read and complete form <u>prior to your appointment</u>. Email the completed form to gina@ginabhealthy.com . Thank you.

Cancellation/No Show:

Individual appointments are scheduled for a specific time. I cannot fill your reserved time slot without notice and it often affects others who are also trying to get in for an appointment. *You will be charged \$75 for a missed appointment unless I am notified of the cancellation/reschedule at least 48 hours in advance.* Of course, emergencies occur, and it is my discretion to waive the cancellation fee. I can be contacted by phone/text (917-238-5968), gina@ginabhealthy.com

Insurance Coverage:

Medical insurance companies may or may not offer coverage for Medical Nutrition Therapy (MNT). Carefully investigate the type of coverage you have, including the need for referrals. *You are responsible for visits – INVOICES ARE SENT VIA PAYPAL* (cash- IF APPLICABLE or credit card payments through Pay pal are accepted).

Email/Phone Communication:

My practice hours are Monday-Friday from 9:00am-5:30pm. If you have a nonemergency clinical question, I will respond during business hours within 24 hours or at our next scheduled appointment. Any phone calls, texts or emails received between Friday after 5:00pm to Sunday will be addressed on the following Monday.

Confidentiality:

All information disclosed within sessions is confidential as outlined in the HIPAA Notice of Privacy Practices.

Retaining Credit Card Information: *INVOICES ARE PREPAID PRIOR TO APPOINTMENT.*

48-hour notice required to cancel or reschedule an appointment. You will be charged for the appointment if you do not give 48 hours' notice or do not show up for the appointment.

I have read and understand the above information. I agree to authorize Gina Beitmirza, MS, RD to collect a fee from my credit card account based on the information provided above.

Upon your request, Gina Beitmirza, MS, RD can provide you a copy of this form for your records.

Name _____

Date _____

<u>Signature on File</u>

I provide this signature as authorization for payment of all my medical services to Gina Beitmirza, MS, RD.

Signature_____

I understand that any services not covered by my insurance will become solely my (the patient's) responsibility.

Signature of Patient or Legal Guardian

Date

Consent for Communication via Email - Provider to Patient

I hereby consent to have Gina Beitmirza communicate with me via e-mailing regarding the following aspects of my medical care and treatment [test results, prescriptions, appointments, billing, etc.]. I understand that e-mail is not a confidential method of communication. I further understand that there is a risk that e-mail communications between my dietitian and me regarding my medical care and treatment may be intercepted by third parties or transmitted to unintended parties.

Signature of Patient or Legal Guardian

Date

Patient Written Acknowledgement Confirming Receipt of Privacy Notice

I have received Gina Beitmirza MS, RD, LDN, CND, CLT, CCC HIPAA Privacy Notice.

Signature of Patient or Legal Guardian

Date