Dietitians ABQ
A subsidiary of Eating Disorders Treatment Center, LLC

Patient Demographics

Last Name: _____ First Name: _____MI: _____

DOB: ____/____/_____ Gender: _____ SSN:_____-____-_____

Are you enrolled in school? **Yes/No** Full-Time Student ___ Part-Time Student ____

Do you smoke? **Yes/No** How often per day? _____ Religion :_____(optional)

How did you hear about us? _____

Physical Address: _____

City: _____ State: _____ Zip: _____

Mailing Address (If different from above):_____

City: _____ State: _____ Zip: _____

Home Phone: (____)____-_____ Cell Phone: (____)____-_____ Preferred Phone: **Home Cell DO NOT CALL**

E-mail: _____

Insurance:
Primary Insurance Provider _____
Subscriber ID: _____ Group/Plan No: _____ Co-payment Amount: _____
Do you have a Secondary Insurance? **Yes/No** Secondary Provider: _____

Financially Responsible Contact: (Primary Insured Party, If Different Than Patient)
Name: _____ DOB: _____ Relationship to Patient: _____
Address Line 1:_____
City:_____State:_____Zip: _____
Home Phone: (____)____-_____Cell Phone: (____)____-_____Work Phone: (____)____-_____
Emergency Contacts:

Name: _____ Relationship to Patient: _____

Home Phone: (_____)_____-_____ Cell: (_____)_____-_____ Work: (_____)_____-_____

Patient Authorization for Treatment: _____ Date: _____
Parent or Guardian: _____ Date: _____

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DABQ Registered Dietitian – Patient Contract

Appointments: The clinician-patient relationship is a professional relationship that develops in our regularly scheduled appointments, and thus requires responsibility on my part and yours. I will provide services on time and will notify you of any necessary changes at least 24 hours in advance, except in cases of some unforeseen emergency. You will not be charged if I cannot make your appointment time.

If you cannot keep your appointment and cancel with more than 24 hours' notice, I will reschedule with no charge. Please cancel your appointment by phone, not by email or text message. I will confirm that your message was received. **If your appointment is not kept or is cancelled with less than 24 hours' notice you will be charged a $50 no show fee, regardless of the reason for missing the appointment.** This fee must be paid in full prior to the start of the next session. Unpaid bills, plus a $20 collection charge per bill will be turned over to a collections agency after 90 days.

Responsibility and Payment of Fees: Client or financially responsible party accepts full financial responsibility for payment for services rendered by DABQ. Payments are expected at the beginning of the time services are rendered. This ensures all our patients receive the full scheduled time for their sessions. Cash, check or Master/Visa credit cards are accepted.

Phone Contact: I am often not immediately available by phone. If I am not available, please leave a message with your phone number and several times when you may be available for me to call you back when I am available. I will make every effort to return your phone call on the same day with exception of weekends and holidays. Phone calls made after 9:00 pm will be returned the following day. If you cannot reach me by telephone, and you feel that you cannot wait for me to return your call, you should call your family physician, 911, or the nearest emergency facility of your choice.

Other Services: Preparation of documents such as letters about or on behalf of patients, reproductions of appointment notes, or other such documents requested of DABQ staff will be billed at the rate of $90 per hour of preparation time, in nearest quarter hour increments; likewise for time spent traveling on behalf of the patient. Lodging and Transportation Expenses for travel shall be reimbursed for actual expenditures, likewise for Meals and Incidental Expenses during travel, with a daily maximum of $50.00. Legal services such as depositions or consultation with attorneys will be billed at the standard DABQ Clinician rate of $90 per hour.

Recording: For purposes of continued staff training, on occasion, sessions may be recorded via digital video recorder. The recording will then be reviewed solely by DABQ staff and then deleted. This is so our staff can continue training and in no way will be a reflection on you or your session. If you do not want to be recorded at **any time** you may ask to have the recorder turned off and it will be stopped.

Confidentiality: The clinician-patient relationship is confidential; however there are limits to confidentiality according to New Mexico State Law. Those exceptions are highlighted in the "Notice of Privacy Practices" provided at your first session. Our staff will be happy to discuss these exceptions at your request. As a necessary course of business DABQ office staff may on occasion have access to patient privacy protected information. Standard confidentiality requirements of such information pertain to all DABQ staff, both Clinical and Clerical, and that information is made available to staff only on a need to know basis.

Treatment of Minors (when applicable)**:** I agree to allow DABQ staff to treat _____, a minor child in my care/custody, and agree to be financially responsible for such treatment.

I understand that this is a legal and binding contract. I agree and understand all of the above and consent to treatment, or to treatment of my minor(s). Names are as follows:

_____ _____

Patient Signature (s) (or Parent/Guardian) Date

_____ _____

Clinician Signature Date

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Financial Responsibility Contract

A sincere commitment to necessary to help ensure a positive experience while at Dietitians ABQ. That sincere commitment is demonstrated not just by putting as much energy and focus as possible into one's recovery, but also by responsible behavior with regard to attendance at scheduled sessions and payment for DABQ services.

DABQ will file insurance claims on the patient's behalf (or for the financially responsible party). However, the client (or the financially responsible party) is responsible for all co-payments or co-insurance payments, deductibles, and any outstanding balance due in the event there is no insurance coverage, insurance disputes, insurance denials, etc. **Please note: that insurance claims cannot be submitted to the carrier in the event of a missed appointment, and payment for any and all missed appointments is solely the responsibility of the client (or the financially responsible party).**

My initials on each line and signature below confirms that I have read, understand, and agree with the following statements.

____ I have been informed of the DABQ fee for services I require, and that it is my responsibility to contact my insurance provider to learn what my expected co-payment or co-insurance is under my policy, and the amount of any insurance deductible remaining on my account (if any).

____ I understand that if I provide my insurance information to DABQ, DABQ will bill my insurance provider on my behalf for services provided, and apply due diligence to obtain payment for billed services.

____ I understand that I am responsible for any and all insurance policy deductibles and that I need to make the full payment towards the deductible for services provided until my deductible is met.

____ I understand that it is my responsibility to make any co-payment or co-insurance payment under my policy to DABQ at the time services are rendered unless other arrangements have been made in advance and approved in writing with DABQ.

____ I understand that it is my responsibility to render payment in full to DABQ for services provided should DABQ be unable to obtain payment in full from my insurance provider within 45 days of the date of service.

____ I understand that should my account balance exceed $100.00 or 30 days past due, DABQ will charge my credit card on file for the amount due as per my "Credit Card on File Agreement".

____ I understand that after 45 days from date of service, it is my responsibility to attempt to recoup from my insurance provider any payments I have made to DABQ to cover balances due.

____I understand that payment to DABQ for services provided may be made with check, cash, MasterCard or Visa, (including insurance issued Visa/MasterCard benefit cards).

____ **Collection and Attorney Fees and Costs:** In any action incurred to enforce this contract or defend services provided according to this contract, the client will be responsible for any additional fees added as a result of an outside collection agency or any reasonable attorney fees.

Financial questions or special arrangements for payment should be discussed with the DABQ Billing Manager, Gloria Gordon. She can be reached at 505-266-6121 ext. 121.

Patient Signature _____Date _____
Financially Responsible Party (Print) _____
Signature _____Date _____

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CREDIT CARD ON FILE AGREEMENT

Patient Name _____
Please Print First Last Middle Initial

I hereby authorize DABQ, LLC to keep my VISA/MC account information on file for payment and to initiate debit or charge entries on this account only as amounts are owed for services provided the patient named above.

Name on Account _____ Date of Birth: _____
Please Print First Last Middle Initial

Credit Card# _ _ _ _ -_ _ _ _ -_ _ _ _ -_ _ _ _ Exp. Date_____CSV code _____

Card Type (check one) ☐ Visa ☐ Master Card ☐ Discover

Charges are not to exceed: $_____for any single charge

This authorization expires: _____

Billing Address of Cardholder (Please Print)

_____
Street City State Zip

I acknowledge that the origination of ACH or credit card transactions to my account must comply with the provisions of U.S. law. I understand that a debit or charge may be made to my bank account or credit card account periodically to pay for amounts owed. If my bank account or credit card information listed above changes for any reason, I will notify DABQ, LLC. This authorization shall remain in effect until the end date as listed above or until DABQ, LLC has received written notification from me of its termination. In the event of returned ACH or a declined charge, my account will be charged a non-refundable service fee of $35.00 for each occurrence.

_____ _____
Authorized Card Holder Signature Date

Please Return to:
Dietitians ABQ
5203 Juan Tabo Blvd #2E
Albuquerque, NM 87111
(505) 266-6121

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices is a summary of our Privacy Policy and describes how we may use and disclose your Protected Health Information (PHI) to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also lists your rights pertaining to your health information. "PHI" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

An in depth description of your rights is available to you upon request.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

1) PHI may be used and disclosed by your counselor/therapist, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you AND, unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your protected health information that directly relates to that person's involvement in your health care.
2) We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:
   a) **Required By Law:** We may use or disclose your protected health information to the extent that the use or disclosure is required by law
   b) **Public Health:** We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law.
   c) **Abuse or Neglect:** We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect
   d) **Legal Proceedings:** We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative or in certain conditions in response by subpoena, discovery request, or other lawful process.
   e) **Law Enforcement:** We may also disclose protected health information.
   f) **Criminal Activity:** We may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.
   g) **Military Activity and National Security:** When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities;
   h) **Workers' Compensation:** We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

3) Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time
4) Patients are notified that texting is not a HIPPA secure form of communication and any information contained in a text message might be viewed by someone other than the intended recipient.

YOUR RIGHTS

The following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

1) You have the right to inspect and copy your protected health information.
2) You have the right to request a restriction of your protected health information.
3) You have the right to request to receive confidential communications from us by alternative means or at an alternative location.
4) You may have the right to have your registered dietitian amend your protected health information.
5) You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.
6) You have the right to obtain a paper copy of our detailed Privacy Policy upon request.

COMPLAINTS

You may complain to us or to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us.

To make a complaint with DABQ please contact our CEO, Robert Keys.

Phone: 505-266-6121

Email: robert@eatingdisordersabq.com

ACKNOWLEDGEMENT

I acknowledge that I have read and understand the aforementioned privacy practices of DABQ, LLC, and my rights to access and control my Private Health Information as described above.

_____ _____

Patient (Parent/Guardian) Name (printed) Date

_____ _____

Patient (Parent/Guardian) Signature Date

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CONSENT FOR RELEASE OF INFORMATION

I _____(Print Name of Patient or Parent/Guardian) give consent for DABQ, LLC to exchange any and all information (including that relating to substance abuse and medical conditions) pertaining to my treatment, to the extent such disclosure is necessary for coordination of treatment, case management, claims processing, quality assurance, or utilization review purposes.

I understand that:

- I can revoke my consent at any time by submitting a written request to that effect, except to the extent that treatment has already been rendered or that action has been taken in reliance on this consent.
- I do not have to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.
- Release of HIV related information requires additional information.
- This authorization expires _____ (insert applicable date or event) or if no date is indicated, 12 months from the date of signing this form.

With the following specific exception of information and/or persons:

_____,

I authorize DABQ, LLC to exchange information with:

Name and Relationship to Patient	Telephone & Fax Numbers	Email	Date of consent	Patient Initials

My signature below indicates that I have read and understand the stipulations above.

PATIENT SIGNATURE: _____ Date:_____
PARENT OR GUARDIAN SIGNATURE: _____ Date: _____
DABQ, LLC Representative: _____ Date: _____

DABQ, LLC Informed Consent for Telehealth Services

I _____ (name of patient) hereby consent to engaging in telehealth sessions with _____ (name of clinician) as part of my treatment at Dietitians ABQ, LLC.

I understand the following with respect to telehealth:

- My telehealth sessions will occur through interactive audio and video or through audio alone (such as over the telephone).
- The conditions in this *Informed Consent for Telehealth* are in addition to the conditions in the general *DABQ Informed Consent for Treatment* (e.g. my responsibilities for payment and cancellations/no shows, mandatory reporting, etc.).
- I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment at DABQ.
- The laws that protect the confidentiality of my personal information also apply to telehealth. As such, I understand that the information disclosed by my dietitian during the course of my sessions is confidential. However, all mandatory reporting exceptions outlined in the general *Informed Consent for DABQ* also apply to telehealth.
- There are potential risks and consequences from telehealth, including, but not limited to, the possibility that the transmission of my personal information could be disrupted or distorted by technical failures, or the transmission of my personal information could be interrupted by unauthorized persons.
- My clinician will conduct my telehealth session in a private room. In order to protect my privacy, I should find a quiet and private place within my home for the session.
- No permanent voice or video recording is kept of my telehealth sessions.
- Telehealth based services and care may not be as complete or as effective as face-to-face services, especially if there is a poor video and/or audio connection.
- If my clinician believes I would be better served by another form of intervention (e.g. face-to-face services) I will be referred to a health professional who can provide such services in my area.
- If my clinician becomes concerned about my safety before, during or after a telehealth session, she/he may contact my emergency contact and/or emergency services in my local area and dispatch them to my home.
- My insurance may not cover telehealth services and I am responsible for all charges incurred.

To be completed by Dietitian and Patient together:

Name of Patient's emergency contact: _____

Telephone number of Patient's emergency contact: _____

Local area crisis services name(s) and number(s): **_1-855-NMCRISIS (662-7474)_____**

Telephone number my clinician should call to talk to me in the case of a disrupted telehealth session:

_____

_____

Patient Signature | Patient name (printed) | Date

_____

Clinician Signature | Clinician name (Printed) | Date

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Name: _____ **Age:**_____ **Date of Birth:**_____ **Email:**_____
Gender: _____ **Occupation**:_____

General Information

Weight:_____ **Height:**_____
Are you on any medications, herbs, supplements, or homeopathic remedies? Yes / No
_____
_____

Has your physician ever diagnosed you with any of the following?

Health Condition	**Yourself**	**Family History**
High Blood Pressure	☐	☐
Heart attack or congestive heart failure	☐	☐
Stroke	☐	☐
Diabetes	☐	☐
Elevated cholesterol	☐	☐
Thyroid disorders	☐	☐
Gallstones/Gallbladder disease	☐	☐
Kidney stones	☐	☐
Colon Polyps	☐	☐
Cancer	☐	☐
Gastrointestinal complications	☐	☐
Depression or Anxiety	☐	☐
Other:	☐	☐

Nutrition Questionnaire

What do you consider to be a "good weight" for yourself? _____

Have you attempted weight gain in the past year? Y/N Highest Weight:_____ Age:_____
Have you attempted weight loss in the past year? Y/N Lowest Weight:_____ Age:_____
Do you follow a special diet? Y/N If yes, please list:_____

Do you have any food allergies/intolerance to any foods? **Y/N**
If yes, please list:_____

Typical Energy Level: 0 1 2 3 4 5 6 7 8 9 10 Avg. Hours Sleep/Night: _____

Any nausea/vomiting/diarrhea/constipation? Y/N If yes, explain_____

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Please rate your overall diet:
poor ***below average*** ***average*** ***good*** ***excellent***
How often do you eat breakfast? _____ times per week?
never ***rarely*** ***sometimes*** ***usually*** ***always***
How many caffeinated beverages do you drink? _____# per day/week/month
How often do you add salt to foods?
never ***rarely*** ***sometimes*** ***usually*** ***always***

Food & Diet History:
Do you drink alcohol? **Y/N If yes, _____# per ____ day/week/month**
How many meals do you have on a typical day? _____ How many snacks?_____
How many ounces of fluid do you consume per day? _____
Do you smoke? **Y/N If yes _____ # per ____ day/week/month**

Indicate how often you consume the following foods by placing the # of times in the appropriate box:
Example: Milk *2x/day*

Food	Daily	Weekly	<Once/week	Never
Milk				
Other dairy products (yogurt, cheese, ice cream)				
Red meat (beef)				
Poultry (chicken, turkey)				
Fish or seafood				
Green vegetables				
Fresh fruit				

What did you eat and drink yesterday? (If you prefer to send a food log separately, please skip this section.)

TIME:	FOOD OR DRINK CONSUMED:	AMOUNT:

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Have you practiced any of the following behaviors:
Binge Eating **Y/N** In past year? **Y/N** Age:_____
Restrictive Eating **Y/N** In past year? **Y/N** Age:_____
Weight-loss pills **Y/N** In past year? **Y/N** Age:_____
Other weight loss methods, please list: _____

Female Screening Questions: (skip if male)
How old were you when you experienced your first menstrual period? _____ years
How long does your period usually last? _____ days
How many periods have you had in the past 12 months? _____
Do you currently take birth control pills or hormones? (Circle One) Yes No
If Yes, list medication: _____

Exercise Schedule
Please add in the type and duration of training you have planned for each day of the week:

	Sunday	**Monday**	**Tuesday**	**Wednesday**	**Thursday**	**Friday**	**Saturday**
Exercise (include duration and type)							

Please list at least 3 specific nutrition questions and/or goals that you would like to address in our appointment:

1.

2.

3.