Date: _____

ID:
Name:
DOB:

TKS Nutrition, LLC
Healthy Habits for LIFE

Tracey K Sinibaldi,RD,LDN,CDCES
Registered Dietitian
Certified Diabetes Care & Education Specialist

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tksnutrition@verizon.net
www.tksnutrition.com

Below you will find detailed information regarding your rights and responsibilities and established policies of this practice. Please read this carefully and select the checkbox at the end of each section if you agree. Please feel free to ask any questions for clarification:

Agreement to Use Electronic Signatures and Electronic Documents

I agree that the electronic signatures included in this notice are intended to authenticate this writing and to have the same force and effect as manual signatures.

Electronic signature means any electronic sound, symbol or process attached to or logically associated with a record and executed and adopted by a party with the intent to sign such record, including (without limitation) typing a name or clicking a checkbox.

I agree to use electronic documents, notices and contacts "electronic documents", for all future transactions and communications. Electronic documents contain the same information as paper documents, notices and contracts. Paper documents, notices and contracts are available at my request. If I give my consent to use electronic documents, I can later change your mind and request a paper agreement instead.

I agree: YES NO _____ **Initial**

Consent to Treatment

I have read through all the above information and have been clearly advised of my rights and responsibilities as a client of TKS Nutrition LLC, including the HIPAA Notice of Privacy Practices.

I understand these rights and responsibilities and agree to abide by them. I hereby consent to the use and disclosure of my health information for treatment, payment and health care operations purposes as described in the TKS Nutrition, LLC Notice of Privacy Practices. I consent to treatment by TKS Nutrition, LLC to render medical nutrition therapy and to carry out all orders deemed advisable by my attending or treating physician. I understand that no guarantee or assurance has been made as to the results that may be obtained. 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.

I agree: YES NO _____ **Initial**

Informed Consent for Telehealth Consultations

I understand that telehealth is the use of electronic information and communication technologies by a healthcare provider for the delivery of services to an individual when he/she is located at a different site than the provider. I hereby consent to TKS Nutrition LLC providing healthcare services to me via telehealth.

I understand that the laws that protect privacy and the confidentiality of health information also apply to telehealth. TKS Nutrition LLC's telehealth services are provided by Kalix, Inc. and/or Doxy.me, a HIPAA compliant EMR and telehealth platform.

Kalix's and/or Doxy.me telehealth platform uses secure browser to browser technology without the need to download or install any software. All data, video, audio and files are encrypted in both transit and rest. Our telehealth appointments are not recorded in any way, but I understand that I have the right to access any information resulting from the service, as required by law.

To join a telehealth appointment, TKS Nutrition LLC will send me a secure link and code as part of my appointment confirmation and appointment reminder messages, which is sent through email or text message.

I understand that telehealth services are not the same as direct in-person appointment delivery because I will not be in the same room as the healthcare provider. The inability to have direct, physical contact with my healthcare provider is a primary difference between telehealth and direct in-person service delivery.

I understand there are potential risks to this technology, including interruptions, and technical difficulties. I understand that TKS Nutrition LLC or I can discontinue the telehealth appointment if it is felt that the telehealth connections are not adequate for the situation. Good internet download and upload speed is required for quality telehealth services. The recommended minimum upload and download speeds required is 2Mbps. I understand that the quality of my video connection may affect the quality of services provided by TKS Nutrition LLC.

I have had the alternatives to telehealth services explained to me, and I understand that my use of this technology is voluntary. I have the right to withhold or withdraw my consent to use telehealth in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting TKS Nutrition LLC. As long as this consent is in force (has not been revoked), TKS Nutrition LLC may provide healthcare services to me via telehealth without the need for me to sign another consent form.

I agree: YES NO _____ **Initial**

Financial Policy

I understand that I am obligated to ensure that our fees are paid in full. TKS Nutrition LLC will verify my coverage and bill my insurance carrier on my behalf. A quote of benefits and/or authorization does not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations and exclusions of my insurance policy at the time of service. I am ultimately responsible for payment of my bill.

I agree that I will pay any deductible and co-payment or co-insurance as determined by my insurance plan. Those payments will be due at the time of service. Many insurance companies have additional requirements or stipulations that may affect my coverage. I am responsible for any amounts not covered or payable by my insurance. If my insurance denies any part of my claim, I agree to be responsible to pay the full balance. A Superbill can be provided at my request for me to obtain reimbursement.

I am also responsible for:

- Copays payment at the beginning of the appointment. We do not bill for co-pays.
- There is a $25 fee for any returned checks. All payments for a returned check and further payments will be due in cash or money order only.
- If your account is 90 days past due, it will be sent to a collection agency. A $20 collections fee will be issued on top of account balance.

In the event that I fail to pay in full for such charges within fifteen (15) days of demand by TKS Nutrition, LLC, I shall be obligated to pay reasonable and necessary costs, including the reasonable legal fees, and collection expenses, incurred by TKS Nutrition, LLC in pursuing its claim for payment. I acknowledge that TKS Nutrition, LLC may take all necessary steps to collect the debt which may include the use of outside services, such as, collection agencies, attorneys, etc.
Where Medicare benefits are applicable, I certify that the information given by me in applying for payment under Title VIII of the Social Security Act is correct. I assign and request payment of authorized Medicare benefits to TKS Nutrition, LLC and to the dietitians providing medical nutrition therapy service on my behalf for any services furnished to me. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine the benefits for related services.
I have read this financial policy and understand my financial obligation.

I agree: YES NO _____ **Initial**

Cancellation/ Missed Visit/ Late Arrival Policy

I agree to keep all scheduled appointments and be on time. If I cannot attend a scheduled session, I will contact TKS Nutrition LLC to cancel and/or reschedule. There will be no fee if the appointment is canceled before 24 hours business day of the scheduled appointment time. I understand if I miss or cancel with less than 24 hours of notice, then I will be charged $50.00 or an appointment will be deducted from your self-pay package.

Any late arrival, 15 minutes after your scheduled appointment will result in your session either being shortened or the appointment considered missed. You will be charged a $50.00 fee or an appointment will be deducted from your self-pay package.

I agree: YES NO _____ **Initial**

Signature on File Authorization

By signing this statement, I am authorizing Tracey Sinibaldi to complete any necessary insurance claim forms on my behalf. I am also authorizing the release of any medical or other information which may be needed in order to process my claims.

My signature will be kept on file and shall be referred to when insurance claim forms are submitted for healthcare services I have received.

Note: if you are incapable of signing, or are under the age of 18, a parent or legal guardian must sign in your place.

Insured's Signature: _____

Date of birth: _____

Insurance card ID number: _____

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at anytime by contacting us. This authorization will remain in effect until cancelled. I, Judith Shaffer, authorize TKS Nutrition LLC to charge my credit card. I understand that my information will be saved to file for future transactions on my account.

Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____ CVC: _____
Cardholder ZIP Code (from credit card billing address): _____

_____ _____

Customer Signature Date

HIPAA Privacy Policies

I hereby acknowledge that I have received a copy of TKS Nutrition, LLC Notice of Privacy Practices.
I hereby acknowledge that I have read, understand, received a copy and agree to these policies.
HIPAA Privacy Policy included in your packet.

I agree: YES NO _____ **Initial**

Signature

Please sign below if you agree to all policies described above.

Signature: _____ **Date:** _____

Print Name: _____ **Date of Birth:** _____