Informed Consent for Nutrition Services

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I am employing the nutrition-counseling services of Client Centered Nutrition, PLLC (Amanda Diede, MPH, RDN, CD) so that I can obtain information and guidance about health factors within my own control (diet, nutrition, and related behaviors) to nourish and support my health and wellness. I understand that the nature and character of the proposed treatment is to provide nutrition-counseling and education that involves information and guidance regarding food, exercise, and/or other health behaviors so that I can strive to improve my health and wellness. The anticipated results of the proposed treatment may include but are not limited to: normalizing my eating behaviors, reducing disordered eating, increasing education on how to nourish my body, reducing eating disorder behaviors, moving toward intuitive eating, and finding peace with food and my body. I understand that the recognized serious possible risks and complications of seeking treatment may be that no progress is made, behaviors/symptoms worsen, or a higher level of care is recommended. I understand that there are possible alternative forms of treatment that may include but are not limited to: not seeking nutrition-counseling or seeing a dietitian at all, or seeking treatment from another provider or specialty. I understand that the recognized serious possible risks and complications of not seeking treatment may be that no progress is made or symptoms/behaviors worsen. I hereby request and consent to Client Centered Nutrition, PLLC (Amanda Diede, MPH, RDN, CD) to provide nutrition-counseling for myself or for the individual I am legally responsible for.

I understand that the clinician at Client Centered Nutrition, PLLC (Amanda Diede, MPH, RDN, CD) is a Registered Dietitian — not physician — and does not dispense medical advice nor diagnose nor prescribe treatment. Rather, she provides education and nutrition-counseling to enhance my knowledge of health as it relates to food and behaviors associated with eating. While nutritional and botanical support can be an important compliment to my medical care, I understand nutrition-counseling is not a substitute for the diagnosis, treatment, or care of disease by a medical provider. Nutritional evaluation or testing provided in nutrition-counseling is not intended for the diagnoses of disease. Rather, these assessment tests are intended as a guide to developing an appropriate health-supportive program for me, and to monitor my progress in achieving my goals.

Disclosure Statement

Although Client Centered Nutrition, PLLC (Amanda Diede, MPH, RDN, CD) is a member of The Seattle Clinic, I acknowledge that she is an independent practitioner solely responsible for the care of her clients. I am hiring Amanda Diede, MPH, RDN, CD, doing business as Client Centered Nutrition, PLLC, not The Seattle Clinic. I agree to indemnify and hold The Seattle Clinic, LLC, and its owners/agents, harmless from any and all claims, of any nature whatsoever, related in any way to the service(s) I am receiving from Client Centered Nutrition, PLLC (Amanda Diede, MPH, RDN, CD). The Seattle Clinic LLC is an intended third-party beneficiary of this agreement and may present this provision as an absolute defense against any suit brought by me (a patient or guardian of a patient) against The Seattle Clinic LLC or its owners/agents.

Consultations

Client Centered Nutrition, PLLC (Amanda Diede, MPH, RDN, CD) regularly consults with professionals regarding clients with whom she is working. This includes meeting with her supervisor. This allows her to gain other perspectives and ideas so that she can better serve me and help me reach my nutrition goals. These consultations are obtained in such a way that confidentiality is maintained. I hereby consent to Client Centered Nutrition, PLLC (Amanda Diede, MPH, RDN, CD) to participate in consultation for myself or for the individual I am legally responsible for.

Practice Policies

Appointments & Cancellation Policy

I agree to keep all scheduled appointments and be on time. If I am late, I understand that the appointment will still end on time out of respect for the client scheduled after me. If I cannot attend a scheduled session, I will call to cancel and/or reschedule. There will be no fee if phone message or conversation is received before 24 hours of the scheduled appointment time. I understand if I miss or cancel with less than 24 hours of notice, then I will be charged for the ***full price*** of the appointment. Client Centered Nutrition, PLLC does not provide refunds.

Credit Card Policy

I understand that Client Centered Nutrition, PLLC, requires keeping your credit or debit card on file as a convenient method of payment. I authorize Client Centered Nutrition, PLLC to keep my card and signature on file and to charge my account for:

- Payment in full for a session in the amount charged by Client Centered Nutrition, PLLC
- For a no-show or missed session without a 24-hour cancellation notice
- The portion of services that insurance doesn’t cover, but for which I am liable
- For past due sessions

Credit card information is kept confidential and secure and payments to your card are processed only after services are rendered. Payments for no-shows or late cancellations will be charged after the time of the scheduled appointment. I authorize Client Centered Nutrition, PLLC to charge the portion of my bill that is my financial responsibility to the credit card entered on the “Credit Card Information” form. I understand that my information will be saved to file for future transactions on my account.

Financial Policy

Client Centered Nutrition, PLLC is currently contracted with Regence, Premera, UnitedHealthcare, First Choice Health Network, Kaiser PPO, and Lifewise. I understand that it is my responsibility to contact my insurance provider ahead of time to determine the extent to which nutrition services may be covered. I understand that if Client Centered Nutrition, PLLC submits an insurance claim and it is denied due to being a non-covered service or not a medically necessary service, I will be charged the amount billed to insurance ($180 for initial assessments - CPT code 97802, and $150 for follow-up sessions – CPT code 97803). Payment must be made within 1 week of receipt of invoice. I understand that I am responsible for fees not covered by insurance such as but not limited to copay, coinsurance, and deductibles at the time of service.

I understand that if Client Centered Nutrition, PLLC is out of network with my insurance, a Superbill can be provided at my request for me to seek reimbursement. I understand that a Superbill does not guarantee insurance reimbursement. I understand it is my responsibility to submit all required

documentation to my insurance company after my appointment (Superbill, physician referral, etc). After submitting my Superbill, my insurance company may reimburse me directly.

I understand that fees for services I receive at Client Centered Nutrition, PLLC that are out of network, a non-covered service, or not a medically necessary service, will be collected at the time of the appointment. Forms of payment accepted include: cash, check, credit cards (Visa, MasterCard, American Express, Discover), debits cards, and health savings cards.

Electronic Communication

Client Centered Nutrition, PLLC cannot ensure the confidentiality of any form of communication through electronic media, including email and text messages. While Client Centered Nutrition, PLLC may try to return messages in a timely manner, Client Centered Nutrition, PLLC cannot guarantee immediate response and requests that you do not use these methods of communication to discuss nutrition counseling content and/or request assistance for emergencies.

ACKNOWLEDGEMENT

I hereby have read, understood, agree, and consent to all the above for myself or for the individual I am legally responsible for. By signing the below I am agreeing that I have read, understood, and agree to the items contained in this document.

Client name: ____

Client signature: ___________________________________ Date (MM/DD/YYYY): ____________

If applicable:

Parent / guardian name: ____

Parent / guardian signature: _________________________ Date (MM/DD/YYYY): ____________

Client (minor) name: ____

Parental healthcare decision making is:

- ☐ Shared
- ☐ Joint with ___________________________ (name)
- ☐ Sole