CHRISTINE ENGSTROM, MS,RD,LD,CEDRD-S
6100 Lake Forrest Dr., Suite 450, Atlanta, GA 30328
Christineengstrom24@gmail.com
(404) 277-5764

Date__________________ Referral Source___________________________
Patient Name ____________________________ Date of Birth __________
Address ____
City_________________ State_________________ Zip Code____________
Home phone _____________________ Cell phone_____________________
Email address____
Social Security Number____
Place of Employment ____
Work Phone____

Financially Responsible Party

Name_________________________ Relation____________ DOB: ______
Address____
City_____________________ State____________ Zip code: ____________
Home/cell phone____________________ e-mail: ______________________

Medical Information

Food Allergies: ____
Allergies____
Current Medications____
Psychiatrist or prescribing Dr. ______________________________________

I hereby authorize treatment by Christine Engstrom, MS,RD,LD,CEDRD-S
I understand that I am financially responsible for all services regardless of insurance benefits. I authorize Christine Engstrom, MS,RD,LD,CEDRD-S to release information to process and secure payment for services. Full fees will be charged for appointments not cancelled 24 hours in advance (48 hours for weekend appointments).

Patient or Guardian
Signature____
Financially Responsible
Party____

CHRISTINE ENGSTROM, MS,RD,LD,CEDRD-S

INFORMED CONSENT FORM & TERMS FOR NUTRITIONAL COUNSELING

I am employing the counseling services of Christine Engstrom, RD so that I can obtain information and guidance about health factors within my own control (diet, nutrition, and related behaviors) in order to nourish and support my health and wellness.

I understand that Christine Engstrom, RD is a Registered Dietitian/Nutritionist and Nutrition Educator and does not dispense medical advice nor prescribe treatment. Rather, she provides education to enhance my knowledge of health as it relates to foods, and behaviors associated with eating. While nutritional counseling and 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.

Privacy

In daily practice, your Dietitian may use facsimile, email correspondence, other written correspondence (for example progress reports to third party payers), and cellular telephone service. In all these instances, confidentiality will be protected as well as possible, but is limited due to the risk of the information being overheard or ending up in the wrong hands. Precautions will be taken whenever possible.

Confidentiality

I understand that Christine Engstrom, RD will keep nutrition notes as a record of our work together. These notes document the topics that we talk about, interventions used, and treatment plan or any other considerations that may be helpful to your work with me.

As a client, your privacy and rights to confidentiality are protected. Confidential information may be disclosed when you, the client, give written valid consent or when a person legally authorized gives consent on your behalf. Information you share with me may be entered into records in written form. All written documentation regarding your treatment will be secured in a private location. Information about you and your treatment will not be shared casually or in public places.

There are some limits to your rights to confidentiality. Information about your treatment may be shared during supervision or consultation with other professionals and or members of your treatment team. When this occurs, this information will be limited to only that which is necessary and relevant for the purpose of supervision or consultation. When possible, your identity will be protected.

The Appointment Hour

A therapy "hour" consists of 45-50 minutes of therapy time. Often times, more time than that is needed, and arrangements can be made for longer therapy sessions, and the fee will be adjusted accordingly. If I am late for an appointment, I will either complete with you the full time of your appointment (assuming your schedule permits this) or owe you the extra time. If you are late, the appointment will end at its scheduled time and you are responsible for full payment.

Payment Policies

You will be financially responsible for all services rendered. <u>I am not on any insurance panels. If you are planning to use insurance for reimbursement, you will be given a special receipt called a superbill with all necessary procedure codes for all sessions and</u>

payments made, and you will be responsible for filing with your insurance company. There is no guarantee that your insurance will reimburse you. I will be happy to assist you with this process by giving your insurance company any needed clinical information, but only at your request and with your written permission. Please note, deductibles must be met before insurance pays any part of the bill. **Payment should be made at the time of session in the office unless other arrangements are made in advance.** Any billing or payment issues should be discussed with me immediately so that we can resolve any problems and address any concerns. A service charge of $40 is required for all returned checks. If you are delinquent with payment, there will be a $25 monthly late fee after 30 days, assessed once a month thereafter until the bill is paid in full.

HIPPA Privacy Form (attached)
I acknowledge that I have read and understand the HIPAA privacy agreement as provided by Christine Engstrom, RD in hard copy form.

I agree to hold Christine Engstrom harmless for claims or damages in connection with our work together. This is a contract between myself and Christine Engstrom, RD and I understand that it is also a release of potential liability.

Nutrition counseling services may be terminated at the discretion of Christine Engstrom, RD if written notification is provided to a client 30 days in advance of final appointment. This will include a listing of referrals for continuity of care.

Client Rights

You have the right to information regarding my training and professional credentials.
You have the right to be treated by me in a consistently competent, ethical and respectful manner.
You have the right to a personal, individual assessment of your treatment needs in which your expertise about yourself is as important as is my professional opinion about you.
You have a right to referrals to other competent professionals and services when this is indicated by your treatment needs.

I certify that all information contained in this form is correct and do not hold Christine Engstrom, MS,RD,LD responsible for any missing, incomplete, or incorrect information. I agree to the terms of nutrition counseling above.

Date: ________________

____

Client or Guardian's Signature

Communication Addendum to the Informed Consent Agreement

Secure and private communication cannot be fully assured utilizing cell/smart phone or regular email technologies. It is the client's right to determine whether communication using non-secure technologies may be permitted and under what circumstances. Use of any non-secure technologies to contact Christine Engstrom, RD will be considered to imply consent to return messages to client via the same non-secure technology, pending further clarification from client. Please check below which modes of communication are permitted and which are not permitted. This consent may be altered at any time should circumstances or preferences change. In the event that client

chooses not to allow non-secure modes of communication, contact will only be made via wire to wire phone, wire to wire fax, or mail. In this case, communication may not be as timely.

Voice communication to client's cell/smart phone for: -Scheduling appointments Appointment reminders	_____Permitted Your telephone number:	_____Not permitted
Voice communication from Christine Engstrom's cell phone 404-277-5764 Between session contact -Scheduling appointments Appointment reminders	_____Permitted	_____Not permitted
-Permitted Fax communication to client's non-secure fax or E-fax for Scheduling appointments Appointment reminders	_____Permitted Fax number	_____Not permitted
Text communication from Christine Engstrom's cell/ smart phone for: Scheduling appointments Appointment reminders Between session contact	_____Permitted Telephone number:	_____Not permitted
Contact via the client's email Scheduling appointments Appointment reminders Between session contact	_____Permitted Email address:	____Not permitted
Teleconferencing based communication to client's portal for:	_____Permitted Email address:	_____Not permitted

Statement of Validation

I have read this Statement of Services, it has been adequately explained to me, and I understand its contents.

Date: _______ Client's signature: ____

Date: _______Client's printed name: _____________________________________

Date: _______Dietitian's Signature: ______________________________________

Christine Engstrom, MS,RD,LD, CEDRD-S

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

CHRISTINE ENGSTROM, MS,RD,LD,CEDRD-S
6100 LAKE FORREST DRIVE, SUITE 450
ATLANTA, GEORGIA. 30328
PHONE: 404-277-5764

Your information:

Name of client:
Address:
Phone Number:
Birthdate:

I hereby authorize the following health care professional, medical facility, mental health facility, laboratory, medical records service, family member to release all health information about me to Christine Engstrom, MS,RD,LD.
The information will be reviewed by Christine Engstrom, RD and discussed with providers for continuity of nutrition care.

PROVIDER #1 MEDICAL DOCTOR/PEDIATRICIAN

Name of client: Person/Organization to Release Information:
Address:
Phone Number:

INTIALS:

PROVIDER #2 PSYCHIATRIST

Name of client: Person/Organization to Release Information:
Address:
Phone Number:

INTIALS:

PROVIDER #3 THERAPIST

Name of client: Person/Organization to Release Information:
Address:
Phone Number:

INTIALS:

PROVIDER #4

Name of client: Person/Organization to Release Information:
Address:

Phone Number:

INTIALS:

PROVIDER #5 THERAPIST

Name of client: Person/Organization to Release Information:
Address:
Phone Number:

INTIALS:

DATE: ________ SIGNATURE: ___________________________________

PRINTED SIGNATURE: _________________________

NOTICE OF PRIVACY PRACTICES - HIPPA

Registered Dietitian – 6100 Lake Forrest Drive, Suite 450 Atlanta, Georgia

Christine Engstrom, MS,RD,LD,CEDRD-S

Effective Date: 8-8-13

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.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable us to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect

to your medical information. If you have any questions about this Notice, please contact our Privacy Officer listed above.

TABLE OF CONTENTS

1. How This Medical Practice May Use or Disclose Your Health Information
2. When This Medical Practice May Not Use or Disclose Your Health Information
3. Your Health Information Rights
4. Right to Request Special Privacy Protections
5. Right to Request Confidential Communications
6. Right to Inspect and Copy
7. Right to Amend or Supplement
8. Right to an Accounting of Disclosures
9. Right to a Paper or Electronic Copy of this Notice
10. Changes to this Notice of Privacy Practices
11. Complaints

A. How This Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured, or after you die.
2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you.
3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We may also share your medical information with our "business associates," such as our billing service, that perform administrative services for us. We have a written contract with each of these business associates that contains

terms requiring them and their subcontractors to protect the confidentiality and security of your protected health information. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their patient-safety activities, their population-based efforts to improve health or reduce health care costs, their protocol development, case management or care-coordination activities, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. We may also share medical information about you with the other health care providers, health care clearinghouses and health plans that participate with us in "organized health care arrangements" (OHCAs) for any of the OHCAs' health care operations. OHCAs include hospitals, physician organizations, health plans, and other entities which collectively provide health care services. A listing of the OHCAs we participate in is available from the Privacy Official.

4. Appointment Reminders. We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone.
5. Sign In Sheet. We may use and disclose medical information about you by having you sign in when you arrive at our office. We may also call out your name when we are ready to see you.
6. Notification and Communication With Family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or another person responsible for your care about your location, your general condition or, unless you had instructed us otherwise, in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with your family and others.
7. Marketing. Provided we do not receive any payment for making these communications, we may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments, therapies, health care providers or settings of care that may be of interest to you. We may similarly describe products or services provided by this practice and tell you which health plans this practice participates in. We may also encourage you to maintain a healthy lifestyle and get recommended tests, participate in a disease management program, provide you with small gifts, tell you about government sponsored health programs or encourage you to purchase a product or service when we see you, for which we may be paid. Finally, we may receive compensation

which covers our cost of reminding you to take and refill your medication, or otherwise communicate about a drug or biologic that is currently prescribed for you. We will not otherwise use or disclose your medical information for marketing purposes or accept any payment for other marketing communications without your prior written authorization. The authorization will disclose whether we receive any compensation for any marketing activity you authorize, and we will stop any future marketing activity to the extent you revoke that authorization.

8. Sale of Health Information. We will not sell your health information without your prior written authorization. The authorization will disclose that we will receive compensation for your health information if you authorize us to sell it, and we will stop any future sales of your information to the extent that you revoke that authorization required by Law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.
9. Public Health. We may, and are sometimes required by law, to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.
10. Health Oversight Activities. We may, and are sometimes required by law, to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by law.
11. Judicial and Administrative Proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.
12. Law Enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying or locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.
13. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.

14. Organ or Tissue Donation. We may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues.
15. Public Safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
16. Proof of Immunization. We will disclose proof of immunization to a school that is required to have it before admitting a student where you have agreed to the disclosure on behalf of yourself or your dependent.
17. Specialized Government Functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.
18. Workers' Compensation. We may disclose your health information as necessary to comply with workers' compensation laws. For example, to the extent your care is covered by workers' compensation, we will make periodic reports to your employer about your condition. We are also required by law to report cases of occupational injury or occupational illness to the employer or workers' compensation insurer.
19. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.
20. Breach Notification. In the case of a breach of unsecured protected health information, we will notify you as required by law. If you have provided us with a current e-mail address, we may use e-mail to communicate information related to the breach. In some circumstances our business associate may provide the notification. We may also provide notification by other methods as appropriate.

B. When This Medical Practice May Not Use or Disclose Your Health Information
Except as described in this Notice of Privacy Practices, this medical practice will, consistent with its legal obligations, not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights

1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information by a written request specifying what information you want to limit, and what limitations on our use or disclosure of that information you wish to have imposed. If you tell us not to disclose information to your commercial health plan concerning health care items or services for which you paid for in full out-of-pocket, we will abide by your request, unless we must disclose the information for treatment or legal reasons. We reserve the right to accept or reject any other request, and will notify you of our decision.

2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.
3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to, whether you want to inspect it or get a copy of it, and if you want a copy, your preferred form and format. We will provide copies in your requested form and format if it is readily producible, or we will provide you with an alternative format you find acceptable, or if we can't agree and we maintain the record in an electronic format, your choice of a readable electronic or hardcopy format. We will also send a copy to any other person you designate in writing. We will charge a reasonable fee which covers our costs for labor, supplies, postage, and if requested and agreed to in advance, the cost of preparing an explanation or summary. We may deny your request under limited circumstances. If we deny your request to access your child's records or the records of an incapacitated adult you are representing because we believe allowing access would be reasonably likely to cause substantial harm to the patient, you will have a right to appeal our decision. If we deny your request to access your psychotherapy notes, you will have the right to have them transferred to another mental health professional.
4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. If we deny your request, you may submit a written statement of your disagreement with that decision, and we may, in turn, prepare a written rebuttal. All information related to any request to amend will be maintained and disclosed in conjunction with any subsequent disclosure of the disputed information.
5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 (treatment), 2 (payment), 3 (health care operations), 6 (notification and communication with family) and 18 (specialized government functions) of Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received

notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.

6. Right to a Paper or Electronic Copy of this Notice. You have a right to notice of our legal duties and privacy practices with respect to your health information, including a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

If you would like to have a more detailed explanation of these rights or if you would like to exercise one or more of these rights, contact our Privacy Officer listed at the top of this Notice of Privacy Practices.

D. Changes to this Notice of Privacy Practices

We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with the terms of this Notice currently in effect. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our reception area, and a copy will be available at each appointment. We will also post the current notice on our website.

E. Complaints

Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be directed to our Privacy Officer listed at the top of this Notice of Privacy Practices.

If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:

OCRMail@hhs.gov

The complaint form may be found at www.hhs.gov/ocr/privacy/hipaa/complaints/hipcomplaint.pdf. You will not be penalized in any way for filing a complaint.

Date: ________ Signature: ____