

Positive Nutrition of Omaha, LLC
 Jessica A. Wegener RD, CSSD, LMNT
 11414 W. Center Rd. Suite 321
 Omaha NE, 68144
Client Registration

Demographic Information & Contact Information

Date: _____

Name:		Date of Birth:
Gender	Marital Status	Pronouns:
Street Address		
City	State	Zip
Phone	Email:	
Parents/Guardian (under 19)	Parent/Guardian Email & Phone:	

Insurance and Billing	
Who is responsible for your bill? Name & phone if different than above: _____	
Insurance Company: _____	
ID Number: _____	Group number: _____
Who carries the insurance and their date of birth: _____	

Please Initial if I may leave a voice message for you. _____ *(Initial)*

Primary Care Physician

Name		Phone
Street Address		
City	State	Zip
How long have you seen your PCP?	_____ Months	_____ Years
Are they aware of your nutrition needs?	Did they fax over a referral?	

Psychotherapist/Counselor

Name		Phone
Street Address		
City	State	Zip
How long have you seen your therapist?	_____ Months	_____ Years
Are they aware of your nutrition needs?	_____ Yes _____ No	

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Psychiatrist/Psychopharmacologist

Name		Phone
Street Address		
City	State	Zip
How long have you seen your therapist?	_____ Months	_____ Years
Are they aware of your nutrition needs?	_____ Yes _____ No	

Consent to Treatment

I/We consent to take part in treatment with Jessica A. Wegener, RD, CSSD, LMNT. I understand that developing a treatment plan with this Registered Dietician and regularly reviewing our work toward meeting the treatment goals are in my best interest. I understand that no promises have been made to me as the results of treatment or any procedures provided by this Registered Dietician. I am aware that I may stop treatment at any time. I am aware that my sessions will be held confidential unless there is a concern of abuse or neglect of a child or a concern that someone may be harmed. I understand that I am financially responsible for my treatment as the patient or guardian and that I am responsible for all charges. **I understand that I must call to cancel an appointment at least 24 hours before the time of the appointment. I understand that I am responsible for a \$40 charge for no-shows and for canceling within 24 hours of a scheduled appointment.** If late cancellations become a pattern the Registered Dietician has the right to terminate treatment and refer the client to a new Dietician if requested.

Patient or Guardian signature: _____

Date _____

Printed Name: _____

Privacy Awareness

I have been aware that **Jessica A. Wegener, RD, CSSD, LMNT** has a privacy policy in place. This notice is to inform me of the ways **Jessica A. Wegener, RD, CSSD, LMNT** and her office will use and share medical information about me. It describes my rights and certain duties **Jessica A. Wegener, RD, CSSD, LMNT** and her office staff have regarding the use and disclosure of medical information.

By signing this form, you acknowledge you are aware of Notice of Privacy practices for Jessica A. Wegener, RD, CSSD, LMNT and give Jessica A. Wegener, RD, CSSD, LMNT permission to speak with and disclose your protected health information with the treatment providers listed on the Client Registration form.

Parent/Guardian Signature _____ Date _____

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Client Agreement

At Positive Nutrition of Omaha, we want nothing more than to meet each of your expectations and help you achieve each of your nutrition goals. We utilize the following guidelines to help us work together in the best possible way. If you have additional questions, please feel free to ask at any time.

_____ (initial) Positive Nutrition of Omaha (PNO), LLC, or any representative of PNO will not disclose any protected healthcare information without my permission except in cases where the provider deems the client is a danger to self or others or there is evidence that requires information to be reported to an appropriate authority.

_____ (initial) Information provided by the Registered Dietitian does not replace the care of a physician. Regular contact with the client's medical provider is strongly encouraged. PNO will be happy to provide information regarding the client's nutrition care to any members of the healthcare team for which a release of medical information form is completed.

_____ (initial) All payments are due at the time of service, \$150 for the Initial Nutrition Assessment and \$60 for follow-up sessions. There is a 4% convenience fee for using credit card payments. If for any reason this is not possible, please contact PNO to arrange payment. A billing statement will be provided at the end of each month in the event an outstanding balance remains and must be paid within 30 days or services may be discontinued until balance is paid in full. If balances are left unpaid, the client gives permission to PNO to use basic demographic information to secure payment.

_____ (initial) PNO can submit insurance for billing, in the event that nutrition services are not a covered benefit or the claim is denied, the client is responsible for the entire balance.

_____ (initial) PNO asks that you make effort to arrive on time to scheduled appointments. We realize that all our lives are busy, and you may have to cancel from time to time. Please give 24 hours' notice so that your appointment time can be offered to another client. If you are unable to give a 24-hour notice of cancellation then a \$40 cancellation fee will be charged and billed at time of service.

_____ (initial) The client will not hold PNO liable for any injury that may occur in the PNO clinic.

Client/Date _____

Witness/Date _____