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| **Patient Name:** | **Date of Birth:** |
| ***Consent to Text***  I consent to receive call and/or text messages from Northwest Family Nutrition, LLC for my protected healthcare and other services on my wireless number provided I understand I may be charged for such calls/texts by my wireless carrier and that such communication may be non-confidential. | ***Initial:*** |
| ***Consent to Bill***  I hereby authorize Northwest Family Nutrition, LLC to bill my insurance company for direct reimbursement for medical nutrition therapy surrendered to the above-named patient. Benefit payment will be assigned directly to Northwest Family Nutrition, LLC. | ***Initial:*** |
| ***Consent to Treat***  I understand that the above-named patient has a diagnosis requiring Medical Nutrition  Therapy and voluntarily consents and authorizes such care by Northwest Family Nutrition, LLC, as may be beneficial in the professional judgment of the patient’s dietitian and primary care physician. I am aware that no guarantee has been made as to the effect of medical nutrition therapy on the patient. I am aware that Northwest Family Nutrition, LLC, provides educational opportunities for students. Students and other health care professionals may attend treatment sessions to learn and observe treatments being performed or led by the Registered Dietitian. I give my ​consent for other professionals and students to participate in treatment sessions. I have the right to withdraw this consent on any day if I choose to do so. I authorize Northwest Family Nutrition affiliates to release, receive or exchange verbal and written information in my medical record and other related information to my insurance company, related healthcare provider, case manager, assignees and/or beneficiaries and all other related persons as it relates to my treatment or payment for services provided.  Providers release: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ***Initial:*** |
| ***Cancellation Policy***  Northwest Family Nutrition, LLC requires 24-hour notice for all cancellations and rescheduling. If the patient misses a scheduled appointment and does not provide minimum 24 hours’ notice including initial appointments, a $35 fee will be charged to the patient and your next scheduled appointment may be 4-8 weeks out. | ***Initial:*** |
| ***Acknowledgement of Receipt of Privacy Policy & Patient Rights***  I acknowledge that I have received and read the patient rights, I decline a written copy of Northwest Family Nutrition, LLC Notice of Privacy Policy Practices with an effective date of 9/1/2011, as it relates to the patient stated above. | ***Initial:*** |
| **Parent/Guardian Printed Name** |  |
| **Patient/Guardian Signature:** | ***Date*** |