Practice Policies/HIPPA

ID:
Name:
DOB:

Below you will find detailed information regarding your rights and responsibilities and established policies of this practice. Please read this carefully and 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

You 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 check box.

You 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 your request. If you give your consent to use electronic documents, you can later change your mind and request a paper agreement instead.

I agree:

Appointments

I agree to keep all scheduled appointments and be on time. 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.

I agree:

Financial Policy

Nutrition Force, LLC is not a preferred provider on any insurance networks or for Medicare. All services must be paid for at time of render. A superbill can be provided at your request for you to seek reimbursement. We accept cash, credit cards and debit cards.

I agree:

HIPAA Privacy Policies

Is supplied below. Please click on the document icon to view.

- Notice of Privacy Practices (HIPAA).pdf

I agree:

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 Kristi Chipman, including the HIPAA Notice of Privacy Practices.

I understand these rights and responsibilities and agree to abide by them. I consent to treatment, and 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:

Signature

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

Name:
Date of birth: