

WELCOME LETTER

Congratulations. You've made a decision to improve the quality of your life through nutrition therapy. This involves not only addressing what you eat, but also how you think and feel about food and your body. As you may have already read on my website, this is not a one size fits all approach. I will strive understand your needs, preferences, and goals in order to offer realistic and personalized solutions for your nutrition and health concerns. I hope to create a relationship built on trust so that we can honestly and openly communicate with one another. Please visit my website at www.marciRD.com for more information about my background, philosophy, along with other services offered.

Because our habits are deeply engrained, making changes that will last a life time occurs in stages and often takes time. Be patient. People often wonder how many times we'll need to meet. That entirely depends on the purpose of our meeting, your goals, your readiness to change, what support systems you have in place, and many other factors. While I might not be able to answer that question definitely, here's what you can expect.

Initial session: Lifestyle and nutrition assessment, baseline goal setting and development of nutrition and/or exercise care plan based on your needs. Please bring the following items to your first appointment*. Note: they are located on the following pages.

- 1.) Privacy Agreement
- 2.) Payment & Cancellation Agreement
- 3.) Nutrition Consultation Questionnaire
- 4.) 3 Food Logs

*Do your best to have all of this information filled out for our first session. If you become overwhelmed, have trouble or don't feel comfortable answering any of the questions, leave it blank! If there is additional info you'd like to include, please feel free to do so.

Subsequent sessions: Re-evaluation of your nutrition and/or exercise care plan, review of goals and objectives, evaluation of follow up laboratory work (as needed), discussion about other resources that may help you meet your goals (i.e. nutritional supplements, working with a therapist, books to read, etc).

FEE-FOR-SERVICE PRICING STRUCTURE FOR CONSULTATIONS

Initial Visit (75 minutes) \$125
Follow-up Visit (45 minutes) \$85
Follow-up Visit (25 minutes) \$45

Package Pricing

- 1 Initial Visit, 5 Follow-up Visits (45 minutes) \$500
- 1 Initial Visit, 5 Follow-up Visits (25 minutes) \$375

PLEASE READ CAREFULLY

- All appointments may be paid with cash or check prior to the start of the visit. (Please make all checks payable to Marci Anderson.)
- Marci RD Nutrition Consulting accepts Blue Cross Blue Shield and Harvard Pilgrim insurance. Please check with your insurance carrier to identify coverage for nutrition counseling prior to our first appointment. Co-pay may be given in the form of cash or check.
- If your insurance rejects an insurance claim, you will be responsible for paying for the session in full.
- If I do not currently accept your insurance can also provide you with a superbill, which you can submit to your insurance company for reimbursement purposes.
- All appointment cancellations must be completed 24 hours in advance. Failure to cancel within 24 hours will still require full payment of the service.
- There will be a \$30.00 charge for all returned checks.
- Appointments start on time. If you are late, you can use the remaining time of your appointment but not beyond that. You will be required to pay for the entire cost of the visit.
- For any concerns, please contact via email at marci@marciRD.com or by phone at 617-834-7336.

Sincerely,
Marci E. Anderson MS, RD, LD, cPT

Marci RD Nutrition Consulting
22 Hilliard St. Cambridge, MA 023138
marci@marciRD.com
617-834-7336

HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date: January 1, 2009

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice, please contact Marci E. Anderson.

MY PLEDGE REGARDING PROTECTED HEALTH INFORMATION:

I understand that protected health information about you and your health is personal. I am committed to protecting health information about you. This Notice applies to all of the records of your care generated by me. This Notice will tell you about the ways in which I may use and disclose protected health information about you. It also describes your rights and certain obligations I have regarding the use and disclosure of protected health information.

The law requires me to:

- make sure that protected health information that identifies you is kept private;
- notify you about how I protect protected health information about you;
- explain how, when, and why I use and disclose protected health information;
- follow the terms of the Notice that is currently in effect.

I am required to follow the procedures in this Notice. I reserve the right to change the terms of this Notice and to make new Notice provisions effective for all protected health information that I maintain by:

- posting the revised Notice in my office and
- making copies of the revised Notice available upon request.

HOW I MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU.

The following categories describe different ways that I may use and disclose protected health information about you without your written authorization.

- **For Treatment.** I may use and disclose protected health information about you to provide you with, coordinate, or manage your medical treatment or services. Specifically, I may share protected health information about you to the physician, therapist, or other health professional or agency that referred you to me, as part of my effort to coordinate your follow up care. I may also share protected health information about you in order to coordinate different things you need, such as prescriptions, lab work, or psychological services. I may disclose protected health information about you to people who provide services that are part of your medical care. And, I may use and disclose protected health information to contact you as a reminder that you have an appointment with me for medical nutrition therapy.
- **For Payment of Services.** I may use and disclose protected health information about you so that the treatment and services you receive from me may be billed to and payment may be collected from you, an insurance company, or a third party. For example, I may need to give your health plan information about the nutrition services you received so your health plan will pay me or reimburse you for the service. I may also tell your health plan about the nutrition services you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.
- **For Health Care Operations.** I may use and disclose protected health information about you for my health care operations, such as my quality assessment and improvement activities, case management, business planning, customer services, and other activities. These uses and disclosures are necessary to run my practice, reduce health care costs, and make sure that all of my clients receive quality care. For example, I may use protected health

information during professional supervision to review my treatment and services and to evaluate my performance. I may also combine protected health information about many of my clients to decide what additional services I should offer, what services are not needed, and whether certain treatment approaches are effective. I may also disclose information to doctors, nurses, therapists, fitness professionals, or other dietitians for review and learning purposes. I will always remove information that identifies you from this set of protected health information so others may use it to study health care and health care delivery without learning who the specific clients are.

Subject to applicable state law, in some limited situations the law allows or requires us to use or disclose your protected health information for purposes beyond treatment, payment, and operations. However, some of the disclosures set forth below may never occur in my practice.

- **As Required By Law.** I will disclose protected health information about you when required to do so by federal, state, or local law.
- **Research.** I may disclose your protected health information to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information
- **Health Risks.** I may disclose protected health information about you to a government authority if I reasonably believe you are a victim of abuse, neglect, or domestic violence. I will only disclose this type of information to the extent required by law, if you agree to the disclosure, or if the disclosure is allowed by law and I believe it is necessary to prevent or lessen a serious and imminent threat to you or another person.
- **Judicial and Administrative Proceedings.** If you are involved in a lawsuit or dispute, I may disclose your information in response to a court or administrative order. I may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made, either by us or the requesting party, to tell you about the request or to obtain an order protecting the information requested.
- **Business Associates.** I may disclose information to business associates who perform services on my behalf (such as billing companies); however, I require them to appropriately safeguard your information.
- **Public Health.** As required by law, I may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.
- **To Avert a Serious Threat to Health or Safety.** I may use and disclose protected health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- **Health Oversight Activities.** I may disclose protected health information to a health oversight agency for activities authorized by law. These activities include audits, investigations, and inspections, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- **Law Enforcement.** I may release protected health information as required by law, or in response to an order or warrant of a court, a subpoena, or an administrative request. I may also disclose protected health information in response to a request related to identification or location of an individual, victims of crime, decedents, or a crime on the premises.
- **Organ and Tissue Donation.** If you are an organ donor, I may release protected health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
- **Special Government Functions.** If you are a member of the armed forces, I may release protected health information about you if it relates to military and veterans activities. I may also release your protected health information for national security and intelligence purposes, protective services for the President, and medical suitability or determinations of the Department of State.
- **Coroners, Medical Examiners, and Funeral Directors.** I may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. I may also disclose protected health information to funeral directors consistent with applicable law to enable them to carry out their duties.
- **Correctional Institutions and Other Law Enforcement Custodial Situations.** If you are an inmate of a correctional institution or under the custody of a law enforcement official, I may release protected health

information about you to the correctional institution or law enforcement official as necessary for your or another person's health and safety.

- **Worker's Compensation.** I may disclose information as necessary to comply with laws relating to worker's compensation or other similar programs established by law.
- **Food and Drug Administration.** I may disclose to the FDA, or persons under the jurisdiction of the FDA, protected health information relative to adverse events with respect to drugs, foods, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

YOU CAN OBJECT TO CERTAIN USES AND DISCLOSURES

Unless you object, or request that only a limited amount or type of information be shared, I may use or disclose protected health information about you in the following circumstances:

- I may share with a family member, relative, friend, or other person identified by you protected health information directly relevant to that person's involvement in your care or payment for your care. I may also share information to notify these individuals of your location, general condition, or death.
- I may share information with a public or private agency (such as the American Red Cross) for disaster relief purposes. Even if you object, I may still share this information if necessary for the emergency circumstances.

If you would like to object to use and disclosure of protected health information in these circumstances, please call or email me.

YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU.

You have the following rights regarding protected health information I maintain about you:

- **Right to Inspect and Copy.** You have the right to inspect and copy protected health information that may be used to make decisions about your care. Usually, this includes medical and billing records. To inspect and copy protected health information that may be used to make decisions about you, you must submit your request in writing to me. If you request a copy of the information, I may charge a fee for the costs of copying, mailing, or other supplies associated with your request, and I will respond to your request no later than 30 days after receiving it. There are certain situations in which I am not required to comply with your request. In these circumstances, I will respond to you in writing, stating why I will not grant your request and describe any rights you may have to request a review of my denial.
- **Right to Amend.** If you feel that protected health information I have about you is incorrect or incomplete, you may ask me to amend or supplement the information. To request an amendment, your request must be made in writing and submitted to me. In addition, you must provide a reason that supports your request. I will act on the your request for an amendment no later than 60 days after receiving the request. I may deny your request for an amendment if it is not in writing or does not include a reason to support the request, and I will provide a written denial to you. In addition, I may deny your request if you ask me to amend information that:
 - Was not created by me, unless the person or entity that created the information is no longer available to make the amendment;
 - Is not part of the protected health information kept by me;
 - Is not part of the information which you would be permitted to inspect and copy; or
 - I believe is accurate and complete.
- **Right to an Accounting of Disclosures.** You have the right to request an "accounting of disclosures." This is a list of the disclosures I made of protected health information about you. To request this list or "accounting of disclosures," you must submit your request in writing to me. You may ask for disclosures made up to six years before your request (not including disclosures made before April 14, 2003). The first list you request within a 12-month period will be free. For additional lists, I may charge you for the costs of providing the list. I am required to provide a listing of all disclosures except the following:
 - For your treatment
 - For billing and collection of payment for your treatment
 - For health care operations
 - Made to or requested by you, or that you authorized
 - Occurring as a byproduct of permitted use and disclosures
 - For national security or intelligence purposes or to correctional institutions or law enforcement regarding inmates

- As part of a limited data set of information that does not contain information identifying you
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the protected health information I use or disclose about you for treatment, payment, or health care operations or to persons involved in your care. I am not required to agree to your request. If I do agree, I will comply with your request unless the information is needed to provide you emergency treatment, the disclosure is to the Secretary of the Department of Health and Human Services, or the disclosure is for one of the purposes described on pages 2-3. To request restrictions, you must make your request in writing to me.
- **Right to Request Confidential Communications.** You have the right to request that I communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that I only contact you at work or by mail. To request confidential communications, you must make your request in writing to me. I will accommodate all reasonable requests.
- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this Notice at any time by contacting me.

OTHER USES AND DISCLOSURES

I will obtain your written authorization before using or disclosing your protected health information for purposes other than those provided for above (or as otherwise permitted or required by law). You may revoke this authorization in writing at any time. Upon receipt of the written revocation, I will stop using or disclosing your information, except to the extent that I have already taken action in reliance on the authorization.

YOU MAY FILE A COMPLAINT ABOUT MY PRIVACY PRACTICES

If you believe your privacy rights have been violated, you may file a complaint with me or file a written complaint with the Secretary of the Department of Health and Human Services. A complaint to the Secretary should be filed within 180 days of the occurrence or action that is the subject of the complaint. If you file a complaint, I will not take any action against you or change my treatment of you in any way.

Please know that any information submitted via email or over the internet cannot be guaranteed as protected. You are sending this information at your own risk. If you are not comfortable with this policy, please communicate with me by phone, regular mail, or in person. Thank you for understanding.

Please detach, sign/date, and return to me the Acknowledgement Confirming Receipt of Privacy Notice below. I will keep this acknowledgment in your medical nutrition therapy record. Please retain a copy for yourself.

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ACKNOWLEDGMENT CONFIRMING RECEIPT OF PRIVACY NOTICE

I acknowledge receiving a copy of Marci RD Nutrition Consulting HIPAA Notice of Privacy Practices.

Printed Name of Client: _____

Signature of Client: _____ **Date:** _____

Signature of Parent: _____ **Date:** _____
Or Guardian
(if < 18 yrs. old)

Comments:

Payment & Cancellation Agreement

PLEASE READ CAREFULLY

- All services may be paid with cash or check prior to the start of the service.
(Please make all checks payable to Marci Anderson.)
- Marci RD Nutrition Consulting currently accepts Blue Cross Blue Shield and Harvard Pilgrim insurance. Additionally, I may request a superbill, which I may submit to my insurance company for reimbursement purposes.
- If my insurance rejects a submitted claim for any reason, I am responsible and will pay the fee for the service(s) rendered.
- All appointment cancellations must be completed 24 hours in advance. Failure to cancel within 24 hours will still require full payment for the cost of the scheduled appointment.
- There will be a \$30.00 charge for all returned checks.
- Appointments start on time. If I am late, I may use the remaining time of my appointment but not beyond that. I will be required to pay for the entire cost of the visit.

I understand that by working with Marci RD Nutrition Consulting, I must comply with the payment and cancellation policies listed above. This not only respects the time and expertise provided by Marci RD Nutrition Consulting, but will also help me to make progress on the goals and plans that I have committed to. By signing this agreement I am indicating that I understand these policies and agree to adhere to them.

I also understand that the recommendations and education provided by Marci RD Nutrition Consulting should not be used in place of medical advice.

Signature: _____ Date: _____

For questions or comments regarding these policies, please contact Marci RD Nutrition Consulting via email at marci@marcirRD.com or by phone at 617-834-7336.

New Client Registration

Patient Information

Name		DOB	
Address			
Marital Status		SS#	Sex M F

Contact Information- please circle your preferred contact method

Telephone- Day/Evening		Cell Phone	
Email Address			

Insurance Information

Primary Insurance			
Insurance ID #		Group #	Co-Pay
Policy Holder, Name		DOB	Relationship to Client
Policy Holder, Address			Self Spouse Parent Other

Primary Care Physician

Name		Phone #	
Address			
National Provider #			
Relationship with Physician (i.e. what do you see him/her for, when was your last apt, etc.)			

Psychotherapist/Counselor

Name		Phone #	
Address	City	State	Zip
Relationship with Therapist (i.e. how long have you been seeing them, how often do you see them, etc.)			

Psychiatrist/Psychopharmacologist

Name		Phone #	
Address	City	State	Zip
Relationship with Psychiatrist (i.e. how long have you been seeing them, how often do you see them, etc.)			

I give Marci Anderson RD permission to speak with and disclose my protected health information with the above named treatment providers.

Signature: _____

Date: _____

Nutrition Consultation Questionnaire

Name: _____

Date: _____

Occupation (what are you doing in life and are how do you feel about it?): _____

Who do you live with? _____

Emergency Contact: _____

Phone: _____

Family History

Tell me about your family and family dynamics:

What was food like in your house growing up? What's it like now?

Does anyone in your family struggling with weight, body image, or eating disorder issues? Please describe.

Does anyone in your family have a history of chronic illness including (like diabetes, heart disease, high cholesterol, high blood pressure)?

Purpose of Consult

Tell me about the primary purpose of our meeting. If it is for an eating disorder, please give me an abbreviated history of your eating disorder , including any other prior or current treatment.

Weight Information- if this section feels uncomfortable, leave it blank and we can discuss it together

Height: _____ Age: _____ Current wt: _____ Ave wt for the past 2 to 3 years? _____
Weight you feel most comfortable _____ When were you last at that weight? _____
Highest adult weight? _____ Age: _____
Lowest adult weight? _____ Age: _____
Pre-pregnancy weight? _____ How much weight did you gain with pregnancy? _____
Have you lost or gained weight recently? _____ How much? _____ Time frame? _____

Dietary History

Tell me about your dieting history (types of diets, amount of weight lost, short/long-term results, etc.)

If applicable, what methods of restriction do you use? Circle all that apply.

- restrict carbohydrates restrict fats restrict calories skip meals
- restrict snacks restrict meals go on fad diets other _____

If applicable, please list any methods of purging that you use or have used in the past.

If applicable, what are your binge foods? _____

If applicable, what are your safe foods? _____

If applicable, what foods are you afraid to eat? _____

What foods do you genuinely dislike (not related to eating disorder)? _____

Please circle how you currently feel about your body.

- strongly dislike dislike slightly satisfied satisfied very satisfied

Eating Patterns

How many meals a day do you eat? _____ Do you skip meals? _____

If yes, which ones do you skip and why? _____

How often and at what times do you snack each day? _____

What foods do you snack on most frequently? _____

How many meals per week do you eat at a restaurant? _____

Which restaurants do you normally choose? _____

How many meals per week do you eat at fast-food restaurants? _____

How does your meal and snack pattern vary on the weekend vs. during the week? _____

When you feel overwhelmed or life gets busy, do you neglect your eating habits? yes no

If yes, please describe. _____

Do you feel that your life/schedule often conflicts with a healthy eating program? yes no

If yes, please describe. _____

Do you engage in other activities while eating (i.e. reading, driving, watching TV)? yes no

Do you eat at the table? yes no Do you cook? yes no

Do you feel you eat fast? yes no Do you like to cook? yes no

Who does the grocery shopping? _____ Who prepares the food at home? _____

Do you read food/nutrition labels? yes no

What do you look for on labels? _____

Do you travel and/or entertain for business? yes no How often? _____

Please list the usual time that you the following meals and your typical daily intake for each meal.

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Does your diet have a lot of variety or does it tend to be the same from day to day? _____

Do you have any food allergies? _____ If yes, please list: _____

Nutrition Consultation

What do you hope to accomplish through our visit? _____

What are your short-term goals? _____

What are your long-term goals? _____

Exercise and Activity

Have you ever followed a consistent exercise program? yes no

Do you currently follow a consistent exercise program? yes no

If yes, please describe: _____

Do you like to exercise? yes no What physical activity do you like? _____

If I am seeing you for an eating disorder, have past or present exercise habits contributed to it? If yes, how?

Personal Health & Medical History

Please list/describe any medical diagnoses or procedures I should be aware of. _____

Please list your current medications & supplement dosages: _____

Please list/describe any mental health concerns should I be aware of (ie depression, anxiety, OCD, PTSD)? _____

Have you ever been advised by your physician to follow a special diet? (i.e. low salt/cholesterol, no sugar, etc)

yes no What changes did you make at that time? _____

Have you ever worked with a dietitian/nutritionist? yes no If yes, what was your experience? _____

Rate your health: excellent good fair poor

On a scale of 1-10, 10 being the highest, how much support do you need when making lifestyle changes? _____

Do you have a strong support system? Please describe. _____

THANK YOU!!

I look forward to meeting you.

marci  **R.D.**
NUTRITION CONSULTING

Daily Food Log

Day and Date: _____

Time	H	Food & Beverages/Amount	F	Details: Trigger "The Why?", Feelings/Moods, Thoughts, With Who, Where
		B:		
		S:		
		L:		
		S:		
		D:		
		S:		

Hunger and Fullness Scale:

1 = Starving	2 = Very Hungry	3 = Ready for a Meal	4 = Edge of Hunger, Snack Time	5 = Neutral	6 = Mildly satisfied- like after a snack	7 = Satisfied- like after a meal	8 = Pretty Full- 2 bites too many	9 = Very full, uncomfortable	10 = Stuffed, need to lie down
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