New Patient Registration

Comprehensive Family Nutrition
Linda Ghiron, MS, RD, LDN

Client Treatment Agreement

I, ____________________________, have agreed to meet with Linda Ghiron for nutrition counseling and understand and accept the following terms:

1. Many insurance plans require referrals from your primary care physician (PCP) for nutrition counseling. Many PCP's offices require referrals be approved prior to the first visit, otherwise a referral will not be issued. If your insurance plan requires a referral, your signature below indicates that you have been notified and understand that if you receive services without the appropriate insurance referral and your insurance does not cover your visit(s), you are financially responsible for payment. In the case that my health insurance does not cover Linda Ghiron's services, I agree to pay her at the following rates:

   Initial appointment: $125
   Follow up appointments: $105

2. I am responsible for any co-payment at the time of my appointment.

3. Kindly call or email 24 hours in advance of your appointment to cancel or reschedule, otherwise you will be billed a $125 fee for an initial appointment or $105 fee for a follow up appointment.

4. I hereby authorize direct payment for nutrition benefits to Linda Ghiron, MS, RD, LDN for services rendered. I understand that it is my responsibility to contact my insurance carrier to inquire about nutrition benefits and that I am responsible for any balance not covered by my insurance.

5. I understand that under HIPAA I have certain rights to privacy regarding my protected health information. My health information will be used to coordinate my treatment or my child's treatment, obtain reimbursement for care and to conduct normal healthcare operations. My counseling sessions with Linda Ghiron will be confidential and the information from my sessions may not be released to anyone without my written consent. I acknowledge that I have received or read a copy of the Notice of Privacy Practices of Linda Ghiron, MS, RD, LDN. I understand that I may request a copy of the Notice of Privacy Practices at any time.

___________________________________ ___________________
Client or Parent/Guardian Signature Date

New Patient Registration

Linda Ghiron, MS, RD, LDN
Comprehensive Family Nutrition
17 Champa Street
Newton, MA 02464
857-636-0255

Release/Exchange of Health Care Information

Patient name: ___________________________________ DOB: _________________________

This form authorizes Linda Ghiron, MS, RD, LDN, of Comprehensive Family Nutrition permission to receive, release and/or share medical records and/or any pertinent information with the following person or agency:

1. Name: _____________________________ Relationship: _________________________

   Address: ____

   Phone: __________________________ Email: _________________________________

2. Name: _____________________________ Relationship: _________________________

   Address: ____

   Phone: __________________________ Email: _________________________________

This information may be shared with the patient or family and will not be sent to any other person or agency. I understand that the information released under this authorization may be privileged and confidential and that this information may not be released without my prior written consent.

I hereby release Linda Ghiron from any legal responsibility or liability that may arise from the disclosure or release of information described above, including liability for or alleged violation of duty to maintain the information in confidence or privacy.

This authorization is valid from the date below unless previously revoked by me.

____ _____________________
Client or Parent/Guardian Date

New Patient Registration

Linda Ghiron, MS, RD, LDN
17 Champa Street, Newton, MA 02464

PATIENT INFORMATION

Name				Date of Birth			
Street		Marital Status		Single Married Divorced Widowed			
City		State		ZIP		Sex	M F

CONTACT INFORMATION, for privacy purposes, please **circle** your preferred contact method

Telephone – day		Cell phone	
Telephone - evening		Email address	

INSURANCE INFORMATION

Primary Insurance				Phone#	
Insurance ID#		Group#		Copay	
Insurance Address					
Policy Holder, Name		Date of Birth		Relationship to Patient	
Address				Self Spouse Parent Other	

Secondary Insurance				Phone#	
Insurance ID#		Group#		Copay	
Insurance Address					
Policy Holder, Name		Date of Birth		Relationship to Patient	
Address				Self Spouse Parent Other	

PRIMARY CARE PHYSICIAN INFORMATION

Name				Phone#			
Address		City		State		ZIP	
NPI#		Referred by:					

☐I have been informed about and acknowledge reading the Notice of Privacy Practices for Linda Ghiron MS, RD, LDN

☐I give Linda Ghiron, MS, RD, LDN permission to speak with and disclose my protected health information with my physician.

☐I understand that a 24 hr cancellation policy exists & that I will be charged for appointments that lack proper notification.

Signature: ____ Date________________________