Miami Counseling & Resource Center

111 Majorca Avenue, Suite B   Coral Gables, FL 33134
Phone (305) 448-8325   Fax (305)448-0687

NUTRITION THERAPY

TREATMENT INFORMATION

"Welcome to our office"

We are pleased to offer you and your family nutrition therapy at the **Miami Counseling and Resource Center.**

Amy Jaffe, M.S., R.D., L.D., is a registered and licensed dietitian/nutritionist with many years of experience and formal training in the treatment of eating disorders and weight related issues.

Enclosed you will find some forms that will aid us in assisting you more effectively.

Appointment cancellations: If you cannot attend a scheduled appointment, kindly notify us as soon as possible. Please be aware that you will be charged for any appointment that is not cancelled **twenty-four (24) hours** in advance.

Amy Jaffe can be reached through her direct voicemail number:
(305) 448-8325 ext. 118

Payment for service: Patients are responsible for the full charge at the time of their appointment. Cash, checks or credit card payments are accepted. Please make checks payable to Miami Counseling & Resource Center/MCRC. There is a $20.00 service charge for any check returned from the bank.

Insurance reimbursement: As mentioned, payment for service is expected at the time of your appointment, however, every effort will be taken to assist you in reimbursement of your payment if nutrition therapy is a covered benefit under your insurance plan. Please discuss this further with the nutrition therapist as needed.

Length of session: The initial nutrition therapy session is 90 minutes in duration. Follow-up sessions are 30 minutes in duration. The fee will be assessed on a prorated basis should the session exceed the scheduled duration of the appointment.

Release of information: Confidentiality is of primary importance. Consequently we adhere to very strict standards regarding the release of records and/or information related to you and your family for your own protection.

Finally, good communication is essential for successful treatment. Please feel free to share with us any of your concerns.

INFORMED CONSENT AND AUTHORIZATION FOR TREATMENT

I hereby consent to nutrition therapy assessment, consultation, and treatment. I have read and agree with the terms stated herein.

___________________________	___________________________
Patient	Amy Jaffe R.D., L.D./N
___________________________	___________________________
Date	Parent/Guardian

____ Copy given to patient (Initials)

Informed Consent for Tele-Nutrition

Tele-nutrition is defined as the provision of nutrition counseling services using telecommunication technologies (e.g. telephone, mobile devices, videoconferencing, e-mail, chat, text, and internet).

Tele-nutrition is a different experience from in-person sessions, e.g. lack of personal face-to-face sessions and the reduced audio/visual cues. This service is not recommended for clients experiencing a crisis. If a life-threatening crisis occurs, you agree to contact a crisis hotline, 911, or to go to the nearest hospital ER.

Every effort will be made to protect client confidentiality by the use of encrypted software. Videoconferencing or chat will be conducted using Zoom and Skype. The client is responsible for protecting devices used, and the environment they are in, in the course of receiving tele-nutrition services to ensure confidentiality.

Text messaging via mobile devices will be used for managing appointments and housekeeping issues only. Telephone sessions are only confidential from landline to landline.

If we schedule for an online session, audio or videoconference and we are unable to connect or are disconnected during the session, attempts will be made to reconnect. If reconnection is not possible, the session can occur by regular voice phone call.

Payment is due at the time of service, via credit, debit, HSA card or mailed personal check.

Cancellation Policy:
As with in-person sessions, if you are unable to keep your appointment, kindly give 24 hours notice to avoid the late cancellation fee.

Thank you!

____
Client's Signature

______________________________ ____________________
Parent/Guardian's Signature Date

PATIENT INFORMATION

NAME:______________________________________,___________________DATE:_________
last first
Name you want to be called:____

ADDRESS:____APT:__________

CITY:_______________________________STATE:__________________ZIP:_____________

HOME PHONE:___________________________WORK PHONE:_______________________

CELLULAR #:______________________E-MAIL ADDRESS:__________________________

SS#__________________SEX: M:____ F:____AGE:______ DATE OF BIRTH:____________

MARITAL STATUS: MARRIED:_______SINGLE:_______DIVORCED:_______

SEPARATED: _______WIDOWED:_______LIVING WITH SIGNIFICANT OTHER:______

REFERRED BY:____

If Internet: key words________________________ search engine?_______________________

REASON FOR REFERRAL:____

EMPLOYER / SCHOOL: ______________________ OCCUPATION:____________________

ADDRESS:____

CITY:_________________________________STATE:_______________ZIP:______________

EMERGENCY CONTACT:

NAME:____________________________________RELATION TO YOU: ___________________

HOME PHONE:_____________ WORK PHONE:____________CELL PHONE:________________

PRIMARY CARE PHYSICIAN

NAME:____PHONE #:__________________

THERAPIST

NAME:____PHONE #:__________________

PSYCHIARIST

NAME:____PHONE #:_________________

Our office prefers payment to be made by:

1) cash 2) check 3) debit card.

However, in an effort to avoid difficulties with your account, please provide credit card information in the space below.

This information will only be used in processing payment due to one or more of the following: copayment balance, returned bank checks, balance for insurance payments made directly to patients, missed or late cancelled appointments, denial of expected coverage by insurance companies or therapy session payment.

Thank you for your cooperation.

CREDIT CARD:

☐ **VISA**

☐ **MASTER CARD**

☐ **DISCOVER CARD**

NUMBER: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

3 DIGIT CODE ON BACK OF CARD ☐

EXPIRATION DATE: ☐☐☐☐

STREET ADDRESS:____

CITY________________________________**STATE:**____________
(Where statement is mailed)

ZIP CODE: ☐☐☐☐☐
(Where statement is mailed)

SIGNATURE:____

PRINT NAME:____

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NUTRITION THERAPY FINANCIAL AGREEMENT

Parent, Spouse or Guardian

I,______________________________, agree to be responsible for the financial obligations of ___________________________ at the Miami Counseling & Resource Center. The charges include.

Initial session:	$_________(90 minutes)
Follow-up session (s)	$_________(30 minutes)

If it is no longer possible for me to continue with this responsibility, I agree to notify in writing the Miami Counseling & Resource Center immediately.

Because the time has been reserved exclusively for my family member, I understand that a twenty-four (24) hour notice of cancellation is required. In the event that the advance notice is not provided, I understand that I will be charged the full fee for the reserved appointment.

Should it be necessary for the Miami Counseling & Resource Center to obtain the services of a collection agency and/or an attorney to collect an overdue balance, the undersigned agrees to pay all reasonable attorney's fees, collection expenses, and court costs incurred in any such action. Balances that have been outstanding over thirty (30) days will begin accruing interest at a rate of 1.5% per month. Interest will continue to accumulate on a monthly basis and will be added to the balance until the entire bill is paid.

_______________________	____________________
Signature (relation)	Witness
_______________________	____________________
Date	Date

Adress:____