SHIRA EVANS NUTRITION LLC, OFFICE POLICIES

Welcome to Shira Evans Nutrition LLC. I look forward to working with you to help you achieve your nutrition-related goals. The following guidelines have been established to facilitate our work together. Please feel free to ask any questions, as I am here to meet your needs.

Confidentiality Policy

Your privacy is very important, and all sessions will be held in strict confidence. A release form will be used to obtain permission to speak with your physician and/or other healthcare providers regarding your treatment. You are not required to sign the release.

Billing and Insurance Coverage Policy

Payment is due before the time of service or immediately following services and will be charged by a HIPAA-compliant platform called Ivy Pay®. Credit, debit, HSA and FSA cards are acceptable forms of payment. A receipt can be provided for services rendered. Shira Evans Nutrition LLC does not accept insurance at this time but can provide you with a monthly Superbill that you can submit to your insurance company. Insurance companies may or may not cover nutrition counseling.

Cancellation and Refund Policy

Time has been specifically reserved for your nutrition appointment. If you need to cancel or reschedule your appointment, please do so by contacting Shira Evans Nutrition LLC via e-mail or phone with a minimum of **24-hours notice from your appointment time**. Appointments not canceled within this time frame will be charged at 100 percent. Your cooperation with this policy is greatly appreciated.

Lateness Policy

Appointments will be held for 15 minutes only. If you arrive within this time period, you will be seen but your appointment time will not be extended. After 15 minutes, your appointment will be forfeited, and you will be charged 100 percent of the session fee (if prepaid, a refund will not be given). Your signature below indicates that you understand and agree to the Office Policies.

Printed Patient Name: _____
Patient Signature: _____ Date:_____
(Parent or legal guardian must sign if the patient is under 18 years of age.)

NOTICE OF PRIVACY PRACTICES

As this notice describes how medical information about you may be used and disclosed, as well as how you may obtain access to such information, please review it carefully. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal Program. It requires that all medical records and other individually identifiable health information used or disclosed by Shira Evans Nutrition LLC in any form (whether electronically, on paper, or orally) are kept properly confidential. This Act gives you, the patient, new rights to understand and control how your health information is used.

HIPAA provides penalties for covered entities that misuse personal health information. As required by HIPAA, Shira Evans Nutrition LLC has prepared this explanation of how Shira Evans Nutrition LLC is required to maintain the privacy of your health information and how Shira Evans Nutrition LLC may use and disclose your health information.

Shira Evans Nutrition LLC may use and disclose your medical records only for the following purposes: treatment, payment, and healthcare operations.

“Treatment” means providing, coordinating, or managing healthcare and related services by one or more healthcare providers. An example of this would include a physical examination. “Payment” means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill

for your visit to your insurance company for payment. “Health Care Operations” include the business aspects of running the practice of Shira Evans Nutrition LLC, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example of this would be an internal quality-assessment review.

Shira Evans Nutrition LLC may create and distribute de-identified health information by removing all references to individually identifiable information. Shira Evans Nutrition LLC may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services, which may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing, and Shira Evans Nutrition LLC is required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to Shira Evans Nutrition LLC:

The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. Shira Evans Nutrition LLC is not however, not required to agree to a requested restriction. If Shira Evans Nutrition LLC does agree to a restriction, Shira Evans Nutrition LLC must abide by it unless you agree in writing to remove it.

The right to reasonable requests to receive confidential communication of protected health information from Shira Evans Nutrition LLC by alternative means or at alternative locations.

The right to inspect and copy your protected health information.

The right to amend your protected health information.

The right to receive an accounting of disclosures of protected health information.

The right to obtain a paper copy of this notice from us upon request.

Shira Evans Nutrition LLC is required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. This notice is effective as of 08/09/2022, and Shira Evans Nutrition LLC is required to abide by the terms of the Notice of Privacy Practices currently in effect.

Shira Evans Nutrition LLC reserves the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post, and you may request a written copy of a revised Notice of Privacy Practices from this office. You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint. Please feel free to contact us for more information. A complaint to the Secretary should be filed within 180 days of the occurrence or action that is the subject of the complaint.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By my signature below, I acknowledge receipt of the Notice of Privacy Practices.
Printed Patient Name:_____
Patient Signature: _____ Date: _____
(Parent or legal guardian must sign if the patient is under 18 years of age.)

PATIENT CONTRACT

Please read the below carefully before signing:

I understand that Shira Evans is a Registered Dietitian. Shira Evans is not a physician trained to diagnose and treat medical problems. I agree to keep the staff of Shira Evans Nutrition LLC informed of any changes in my medical condition. I also acknowledge that the success I achieve in this nutrition program depends on my ability to make permanent changes in my eating and exercise behaviors. I agree to follow up with the staff of Shira Evans Nutrition LLC for scheduled nutrition counseling sessions. I am aware that the staff of Shira Evans Nutrition LLC makes no claims, guarantees, or warranties regarding the results I should obtain under its direction. Successful nutrition therapy involves behavioral changes. To best make these changes, I need to keep my scheduled appointments. If I miss any sessions without making prior arrangements, the missed session(s) will be counted as completed session(s). This is because the scheduled time could have been used for other patients and encourages my compliance with this program. I understand that if I need to reschedule a session, I must do so at least 24 hours in advance to avoid being responsible for the session fee. No refunds or exchanges will be provided during and/or after any consultations without a 24-hour cancellation notice.

Your signature below indicates that you understand and agree to the Patient Contract.

Printed Patient Name:_____
Patient Signature: _____Date:_____
(Parent or legal guardian must sign if the patient is under 18 years of age.)

PATIENT COMMUNICATION PREFERENCES

By signing below, I am hereby permitting the office of Shira Evans Nutrition LLC to call my home or other designated locations and leave a message on my voicemail to assist in performing necessary nutrition-related services. I am also hereby permitting the office of Shira Evans Nutrition LLC to communicate via text message with me to assist in performing necessary nutrition-related services. I hereby give permission for Shira Evans Nutrition LLC reply to my messages via e-mail, including any information that Shira Evans Nutrition LLC deems appropriate that would otherwise be considered

confidential. I understand that Shira Evans Nutrition LLC may at times email me information about resources that I can use as part of my treatment. I hereby consent to receive such information via e-mail.

In signing below, I am hereby permitting the office of Shira Evans Nutrition LLC to e-mail my home or other designated location to assist the office in performing nutrition-related services, such as appointment reminders, patient statements, and information related to the patient nutrition care process. Shira Evans Nutrition LLC will use appropriate safeguards designed to prevent unauthorized use or disclosure of protected health information. However, I understand that the privacy and security of e-mail communication to and from Shira Evans Nutrition LLC cannot always be guaranteed secure and confidential. I hereby agree that Shira Evans Nutrition LLC shall not be liable for any breach of confidentiality that may result from the use of e-mail communications. I understand that Shira Evans Nutrition LLC has advised me not to send identifying information such as social security numbers via e-mail.

I understand that e-mail shall not be used for urgent matters because technical or other factors may prevent a timely answer. I understand that I should contact 911 or visit the nearest emergency room if I am feeling unsafe or experiencing a life-threatening emergency.

I understand that if I use e-mail to request scheduling changes, it is my responsibility to confirm that Shira Evans Nutrition LLC has received my communication more than 24 hours before the appointment time being changed.

I understand that I am free to e-mail Shira Evans Nutrition LLC brief messages or questions but that frequent and more detailed e-mail communication is an additional service that requires payment. I will ask about this service if I am interested in participating.

I understand that all e-mail communications may be made part of my permanent medical record and shall be accessible to anyone given access to those records. I also understand that I may withdraw permission for Shira Evans Nutrition LLC to communicate with me via e-mail by notifying Shira Evans Nutrition LLC in writing.

Printed Patient Name:_____
Patient Signature: _____ Date: _____
(Parent or legal guardian must sign if the patient is under 18 years of age)

RELEASE FORM

I hereby consent to participating in nutrition counseling at Shira Evans Nutrition LLC. I understand that all information I provide is private, confidential, and protected by law. When necessary for the coordination of my nutrition and healthcare, my protected health information may be obtained from and/or provided to my:

Primary Care
Doctor:_____
Address:_____
Phone:_____
Fax: _____

Psychologist, Psychiatrist, or
Counselor:_____
Address:_____
Phone:_____
Fax: _____

Other Healthcare
Practitioner:_____
Address:_____
Phone:_____
Fax: _____

Shira Evans Nutrition LLC is hereby released from any legal responsibility or liability for the release of information authorized herein. I understand that I have the right to revoke this authorization in writing at any time by sending written notification to Shira Evans Nutrition LLC. I also understand that I have the right to inspect or obtain a copy of the protected health information to be provided as permitted under federal and state law. I understand that I have the right to refuse to sign this authorization.

My signature indicates my understanding and acceptance of the above policies.
Printed Patient Name:_____
Patient Signature: _____Date: _____
(Parent or legal guardian must sign if the patient is under 18 years of age.)

PAYMENT FORM
Shira Evans Nutrition LLC uses Ivy Pay® to collect payment for sessions. It works with credit, debit, HSA and FSA cards. It's HIPAA-secure, keeps our nutrition therapy confidential and makes payment easy for you and me. All I will need is your mobile number. Ivy Pay sends you a text message after our first session, helps you enter your payment information, runs the first charge and puts your card on file for ongoing use.
Please note that a 2.75% fee will be added to each credit card transaction

Phone Number (mobile) : _____
Email: _____
I, (please print name)_____, authorize Shira Evans Nutrition LLC to charge my credit card for the following reasons: missed appointments, appointments cancelled within less than 24 hours of my scheduled appointment time, and balances remaining unpaid after 30 days.
A receipt can be e-mailed to you for any charges made. Thank you for your cooperation.
Printed Patient Name: _____
Patient Signature: _____Date: _____