Consent to Treat, Release of Information, & Payment Policy

Patient Condition of Out-patient Treatment:
I hereby authorize and consent to treatment at DuPage Dietitians which includes medical nutrition therapy, nutrition counseling and nutrition education for the treatment of my condition or for preventative and wellness care.

Patient Rights:
I certify fully that I have read and understand the above consent and conditions of treatment and that explanations therein referred were made.

Consent to Release Information:
I authorize DuPage Dietitians to release information and/or provide copies of my medical records, including billing information, medical history and all diagnosis information for the purpose of communication treatment and outcomes to my physician/s, therapist, or other care providers as appropriate.

I understand that my records are protected under Federal Confidentiality regulations and prohibit from making further disclosures without specific consent unless otherwise provided for in the law. I may revoke my consent in writing at any time except to the extent that action has been taken in reliance upon it. This authorization for release expires 12 months after treatment is completed or until full payment is received, whichever is longer

Privacy Policy:
I acknowledge that I have been informed of the DuPage Dietitians Notice of Privacy Practices which can be found on the website. I understand it describes uses and disclosures of my protected health information by DuPage Dietitians and informs me of my rights with respect to my protected health information and that upon request.

Please note: Communicating via email implies an understanding that e-mail may not be 100% confidential, and that by engaging in email practices, you are authorizing DuPage Dietitians to communicate information in this manner.

Payment Policy: For sports nutrition services, payment is expected at the time of the visit. Check, cash or PayPal may all be utilized. There is a small service fee of $5.00-10.00 for using PayPal depending on the total charges.

Agreement:
If you have read and understand the above, please sign and date below. If you have any questions, please ask for clarification.

Printed Name: _____

Signature: _____ Date: _____

Signature of parent or guardian of patient under age 18: _____

Date: _____