



805 Stevens Avenue
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Privacy, Email, and Telehealth Consent

Nutrition Works, LLC needs your consent to use and disclose your protected health information to carry out treatment, payment and coordination of care with your other health care providers and to communicate with you. If you would like a more detailed description of such uses and disclosures please refer to our Notice of Privacy Practices, which you have the right to review before signing this consent. This consent is voluntary. You have the right to revoke this consent in writing, and the revocation will be effective except to the extent Nutrition Works, LLC has already acted in reliance on your consent. Please initial each permission in addition to signing at the bottom of the page.

- I consent to use of my protected health care information to coordinate care with my other health care providers. I give Nutrition Works LLC permission to request medical records from my health care providers for coordination of care and to send a summary note of my consultation to my physicians. _____ (initials)
- I give Nutrition Works, LLC permission to leave messages including personal health information such as the dates and times of appointments at any of my phone numbers. _____ (initials)
- I give Nutrition Works, LLC permission to include Protected Health Information at the email address I provided. I have been informed that the information sent by email is not encrypted. This means a third party may be able to access the information and read it, since it is transmitted over the internet. In addition, once the email is received by me, someone may be able to access my email account and read it. _____ (initials)
- I consent to receive nutrition services at Nutrition Works LLC via a secure telehealth (video-chat) platform, when an office visit is not available. Nutrition Works LLC will provide a link to the videochat at the email address I provided. I know I can stop using telehealth at any time and ask to receive service(s) in a face-to-face setting. However, if I choose face-to-face services, my appointment time and dietitian may change. _____ (initials)

Assignment of Benefits

Nutrition Works, LLC is a participating provider for many insurance plans. However, insurance policies vary greatly in their coverage of medical nutrition therapy and telehealth; our participation is NOT a guarantee of coverage.

- I understand it is *my* responsibility to know what benefits my employer/group has selected for coverage and to contact my insurance company with coverage questions prior to my visit. I understand that Nutrition Works, LLC may require a referral from my physician or pre-authorization from my insurance company. However, I understand a referral from my physician does not mean nutrition counseling or telehealth are covered benefits on my insurance policy.
- I authorize Nutrition Works, LLC to apply for benefits on my behalf for services rendered. I certify that the insurance information I have provided is correct and I authorize the release of all information, including medical information, for this or related claims.
- I understand that Nutrition Works, LLC will bill me for services rendered if my insurance company denies or rejects payment of my claim. I understand I am financially responsible for any remaining balance, such as co-payments, deductibles, cancellation or no-show fees. I understand if my account is 90 days past due, it will be sent to a collection agency; a \$25 collection fee will be issued.
- I understand there is a \$25 fee for returned checks.

Signed _____ Date: _____