Thank you for making an appointment with one of our providers!

Here are some helpful reminders for your initial visit.

Address:
33 6th Street South, Suite 205
Saint Petersburg, FL 33701
(Same building as "City Gym")
We are located in downtown St. Pete on the corner of 1st Avenue South and 6th Street. We are across from Hippo Popsicle and Cider Press Café.

Parking:
Parking available in marked spaces 52, 53, 54 (along the alley)
Please park in designated spaces ONLY, (the towing company is very aggressive)
Free 2-hour city street parking is also available.

Entrance:
The entrance to the building is on the east side (not the sliding glass doors side). If the door is locked, the code is **5030*** Take the elevator up to the 2nd floor. We are in suite 205 up the hall on the left.

PERSONAL DATA	
Patient's Name:	
DOB:	**Gender:**
Age:	**Phone Number:**
Address	**Referred By:** ☐ Google ☐ Social Media ☐ Friend ☐ HealthProfs ☐ Doctor ☐ Other ___________

Concerns:

What health and/or nutrition concerns would you like to focus on during your visit?

1.

2.

3.

ANTRHOPOMETRIC DATA	
Height:	**Last known weight:** **Date:**
High weight:	Date:
Low weight:	Date:
Typical/ Usual weight:	Comments:
Desired weight:	Fear weight:

Explain any significant weight changes in the last:

3 months: ____

6 months: ____

12 months:____

PERSONAL HISTORY

Have you used/engaged in any of the following:

☐ Laxative	☐ Diet pills	☐ Prescription drug use/misuse
☐ Caffeine	☐ Supplements	☐ Alcohol
☐ Diuretics	☐ Enemas	☐ Illicit drug use
☐ Dieting	☐ Fluid extremes	☐ Self-harm/Suicide attempts

If yes, explain:

What type of physical activity/exercise do you enjoy?
Frequency of activity/exercise:
Do you or have you engaged in what you believe to be compulsive exercise? If yes, explain:
Prior work with RD:
Nutrition/wellness-related goals:
DIET HISTORY
Barriers to grocery shopping/cooking/eating:
Do you go out to restaurants? If yes, how frequently:
Who do you typically eat with?
Who prepares your meals?
Are you responsible for preparing meals for others at home?
TYPICAL DAY OF EATING (INCLUDE TIMES IF POSSIBLE)
Breakfast:
Lunch:
Dinner
Snacks (and times):
Fluids:

PHYSICAL SYMPTOMS AND MEDICAL HISTORY
Medical conditions:
Recent Surgeries or Hospitalizations:
Noted changes to hair, skin or nails:
Problems with chewing/swallowing/sensitive teeth/cavities/etc: □ Yes □ No
If yes, explain:
Do you have physical hunger/fullness cues? □Yes □No
Digestive issues:
□ Reflux □ Heartburn □ GERD □ Esophageal □ IBS □ Crohn's □ Coeliac □ Constipation □Diarrhea □Other ____ If yes to any, please explain:
Age of Menses: Last menstrual cycle:
Have you ever had a period of amenorrhea or irregular periods? □Yes □No If yes, please explain:
Hormone therapy? □Yes □No If yes, please explain:
Bone density scan? □Yes □No If yes, were there significant results?
Do you have food allergies? □Yes □No If yes, please list with reaction type:
Do you have food intolerances? □Yes □No If yes, please list with reaction type:

Do you follow a diet prescribed by a registered dietitian, or has your doctor recommended you follow a prescribed diet in the past? □Yes □No If yes, please explain:
Are you vegetarian? □Yes □No Type: If yes, for how long have you been vegetarian?
Do you take any dietary supplements? □Yes □No List type and reason for taking:
Medications prescribed that may impact nutrition status:
Notes:

NEW CLIENT INFORMATION AND RESPONSIBILITY FOR PAYMENT

Welcome to the Integrated Care Clinic. This information is intended to answer many of your questions about our basic policies and procedures. If you have any questions, please don't hesitate to ask your practitioner about these or any other matters when you meet. We are here to assist you.

CONFIDENTIALITY:

Communication between you and your clinician is considered privileged and confidential. We will not release any information without your written release. The billing information we give to you for your insurance carrier provides only information about the dates of service, diagnosis, and procedure codes. The only exception to these conditions may occur in situations such as child abuse, danger to life, or workers' compensation where by law other action is permitted. Please discuss this with your clinician.

OFFICE HOURS

The office staff are typically available from 9:00 a.m. to 6:00 p.m. Monday through Friday, and by appointment only on Saturdays. When the office is not open, please call your clinician's number and leave a message. The first priority and our primary concern is your well-being. In an emergency, please go to the nearest hospital emergency room (ER) for help with your problem, and contact us by saying "This is an emergency!"

If your clinician is out of town or unavailable for some other reason, one of our other office staff will be on-call.

SCHEDULING APPOINTMENTS

An appointment can be scheduled by your clinician.

APPOINTMENT LENGTH:

Nutrition Counseling appointments are billed on 60 or 30 minute sessions. If an appointment runs longer, you will be charged for the additional time. The charge will be determined and prorated on the basis of each additional 15 minutes of time.

The first session involves assessment and usually lasts for one to one and one-half hours. Your clinician will discuss with you any further assessment or testing that they feel is appropriate and necessary. The fees for these services will also be discussed at this time.

FEES SCHEDULE:

Payment is due at the time service is provided.	Rates
Individual Intake (60 Minutes)	$175
Individual/Family Nutrition Counseling Session (60 Minutes)	$120
Individual/Family Nutrition Counseling Mini-Session (30 Minutes)	$60
Six 60-Minute Session Package	$650*
Six 30-Minute Mini-Session Package	$325*

* Packages are to be paid in full at the time of purchase and are not refundable or transferrable.

However, you may space them out at your convenience.

If an appointment runs longer, or you need to speak to your clinician over the phone (other than to reschedule) you will be charged for the additional time. The charge will be determined and prorated on the basis of each additional 15 minutes of time ($40 per 15-minutes).

MISSED APPOINTMENTS:

A missed appointment occupies a significant portion of our professional time and may reflect an issue that we ought to discuss. As importantly, a missed appointment keeps us from someone else in need of our services.

Therefore, except in the case of an acute emergency or illness, we require a 24 hour notice of any cancellation; otherwise, your account will be charged for the visit. If our office is closed, leave a message on your clinician's voice mail to inform us of your cancellation so the time may be used appropriately.

PAYMENT:

Payment for professional services are due and payable at the time they are rendered. All clients are expected to take care of their fees as services are rendered. Any other arrangement is considered a special arrangement and must be discussed in advance with your clinician. Delinquent accounts may be referred to a collection agency. There is a $25 fee per late payment. We accept cash, checks, Visa, and Mastercard, and American Express.

In all cases, collection of insurance benefits or any other arrangement regarding third party payment is the responsibility of the client (parent or guardian, if the client is a dependent child). An insurance receipt is available for your convenience in submitting your insurance claim for reimbursement. Additional copies of bills can be made for you on request.

I have read and understand these policies. I acknowledge responsibility for all fees incurred.

Date: ___________________

____

Client's Name

____

Signature of Responsible Party

INFORMED CONSENT FOR PSYCHOLOGICAL SERVICES:

I hereby voluntarily apply for and consent to Nutrition Counseling services from ___Jacqui Supplee_____

This consent applies to myself, ward, or client named below. Since I have the right to refuse services at any time, I understand and agree that my continued participation implies voluntary informed consent.

I understand that the potential benefits of receiving Nutrition Counseling services may include obtaining a professional opinion, reduction of symptoms, and an increased understanding of nutritional issues. I understand that potential risks may include possible disagreement with the professional opinions offered, possible emotional distress when addressing my or my child's difficulties, and limitations in the ability to make predictions based on results of assessments (when applicable). I understand that alternative procedures include services provided by another psychologist, a psychiatrist, or another mental health professional. I understand that I may ask for a referral to provider if I am not satisfied with my services.

I understand and agree that disclosures and communications are considered privileged and confidential except to the extent that I authorize a release of information, or under certain other conditions listed below:

1. where abuse or harmful neglect or children, the elderly, or a disabled or incompetent individual is known or reasonably suspected
2. where the validity of a will of a former patient is contested
3. where such information is necessary for the practitioner to defend against a malpractice action brought by the client
4. where an immediate threat of physical violence or suicide against a readily identifiable victim is disclosed to the practitioner
5. where the client, by alleging mental or emotional damages in litigation, puts his/her mental state at issue
6. where the client is examined pursuant to a court order.

I hold Jacqui Supplee harmless for releasing information under the above conditions.
(Integrated Care Clinic Clinician)

Client's Name: ____ Date of birth: _______________

Client Signature: ____ Date: ___________

PERMISSION TO RELEASE AND OBTAIN INFORMATION

I do hereby authorize Jacqui Supplee to release and discuss the results of my:

____ All (no need to check other options)

____ Diagnosis

____ Medications

____ Phone Consultation

____ Treatment Updates & Recommendations

____ Nutritional Evaluation

____ Dates of Nutrition Counseling Sessions

____ Other____

with the following individuals. I give those listed below my permission to discuss and release information regarding myself to Jacqui Supplee .
(Integrated Care Clinic Clinician)

This release of information is valid from ________________(date) to __________________ (date).
(If left blank, it will default to 365 days)

Individual	Agency	Phone Number
1. _______________________________________	_________________________	_________________
2. _______________________________________	_________________________	_________________
3. _______________________________________	_________________________	_________________
4. _______________________________________	_________________________	_________________

Client's Name: ____ Date of birth: _______________

Client Signature (print name) ____

Adult Nutritional Assessment

NOTICE OF POLICIES AND PRACTICES TO PROTECT THE PRIVACY OF HEALTH INFORMATION

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

We may use or disclose y*our Protected Health Information (PHI),* for treatment, payment, and health care operations purposes with your *consent. To* help clarify these terms, here are some definitions:

- *"PHI"* refers to information in your health record that could identify you.
- *"Treatment, Payment, and Health Care Operations"*

  - *Treatment refers to* when we provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another psychologist.

  - *Payment refers to* when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.

  - *Health Care Operations* are activities that relate to the performance and operation of our practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

- *"Use"* applies only to activities within our offices, such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- *"Disclosure "* applies to activities outside of our offices, such as releasing, transferring, or providing access to information about you to other parties.

II. Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, or health care operations when your appropriate authorization is obtained. An *"authorization" is* written permission beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment or health care operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your Psychotherapy Notes. *"Psychotherapy Notes"* are notes we have made about our conversations during a private, group, joint, or family counseling session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke all such authorizations (of PHI or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have relied on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

III. Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- *Child Abuse* -If there is reasonable cause to suspect child abuse or neglect, we must report this suspicion to the appropriate authorities as required by law.

- *Adult and Domestic Abuse* -If we have reasonable cause to suspect you have been criminally abused, we must report this suspicion to the appropriate authorities as required by law.

- *Health Oversight Activities* -If we receive a subpoena or other lawful request from the Department of Health or the Florida Board of Psychology, we must disclose the relevant PHI pursuant to that subpoena or lawful request.

- *Judicial and Administrative Proceedings* - If you are involved in a court proceeding and a request is made for information about your diagnosis and treatment or the records thereof, such information is privileged under state law, and we will not release information without your written authorization or a court order. The privilege does not apply when a third party is evaluating you or where the evaluation is court ordered. You will be informed in advance if this is the case.

- *Serious Threat to Health or Safety* - If you communicate a threat of physical violence against a reasonably identifiable third person and you have the apparent intent and ability to carry out that threat in the foreseeable future, we may disclose relevant PHI and take the reasonable steps permitted by law to prevent the threatened harm from occurring. If we believe that there is an imminent risk that you will inflict serious physical harm on yourself, we may disclose information in order to protect you.

- *Worker's Compensation* - We may disclose protected health information regarding you as authorized by and to the extent necessary to comply with laws relating to worker's compensation or other similar programs, established by law, that provide benefits for work related injuries or illness without regard to fault.

IV. Patient's Rights and Psychologist's Duties

Patient's Rights:

- Right to Request Restrictions - You have the right to request restrictions on certain uses and disclosures of protected health information. However, we are not required to agree to a restriction you request.

- Right to Receive Confidential Communications by Alternative Means and at Alternative Locations - You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are in therapy. On your request, we will send your bills to another address.)

- Right to Inspect and Copy - You have the right to inspect or obtain a copy (or both) of PHI in our mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, we will discuss with you the details of the request and denial process.

Adult Nutritional Assessment

- Right to Amend-, You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.
- Right to an Accounting - You generally have the right to receive an accounting of disclosures of PHI. On your request, we will discuss with you the details of the accounting process.
- Right to a Paper Copy - You have the right to obtain a paper copy of the notice from us upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.
- If we revise our policies and procedures, we will notify you either in person or by mail.

V. Complaints

If you are concerned that one of us has violated your privacy rights, or you disagree with a decision made about access to your records, you may contact the office at 33 6th Street South, Suite 205, St. Petersburg, FL 33701 telephone number (727) 490-8811 and if the situation cannot be resolved, you will be given further information about how to proceed with your complaint under the laws of the State of Florida.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. A person listed at the above location can provide you with the appropriate address upon request.

VI. Effective Date, Restrictions, and Changes to Privacy Policy

This notice went into effect on November 1, 2014

We reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that we maintain. We will provide you with a revised notice in person or by mail.

I further acknowledge that I have received the first three pages of this notice and may keep them for my records.

Client Signature: ______________________________ Date _________________________

Witness: _______________________ Date _________________________________