Kathryn Fink, MS, RDN, LD, CEDRD
214-850-9573
fax 972-255-7997
www.confidenceineating.com
kat@confidenceineating.com

Welcome to a wonderful new way of thinking about food and mood. To make our sessions and your health progress most beneficial, there is some paperwork for you to fill out prior to your appointment.
Please fill this out and send to me prior to your appointment (email or fax).

Step 1
Decide How You'd Like To Pay
The initial 1 hr. Nutritional Assessment and Consultation is $200.00.
Follow-up therapy sessions are $125.00 per 30-45 minutes.
Phone nutrition therapy is $50 per quarter hour segment (6-15 minutes). Payment is due at the time of the office visit. Packages are available and priced according to items in them and time committed, specifics are on the website and can be discussed in person, the phone or email. Cash, checks or credit cards are accepted. There is a $35.00 charge for returned checks.
_____ Read and sign the Payment form
_____ Read and sign cancellation policy

Step 2
Get Ready for Your First Appointment
_____Fill out the medical and family history form and send in. If you have questions, either call 214-850-9573 or email contact@dietitianadvice.com

Step 3
Learn About How We'll Coordinate With Your Healthcare Team
Fill out the form that provides us with contact information for your healthcare team and approval to communicate with them.

Step 4
Contact Us To Schedule Your Appointment at 2701 Wallin Dr Irving TX 75062

You can schedule by contacting me at 214-850-9573 or kat@confidenceineating.com
____ Send in your Payment form/cancellation policy
____ Send in your Personal & Medical history
____ Send in your HIPPA/Disclosure page
Note, my email does not use encryption, so it is not secure but I have not had any problems. You can choose to email, mail (2701 Wallin Dr. Irving, TX 75062) or fax your forms in to my personal office fax at 972-255-7997. Your forms must be received to confirm your appointment no later than 72 hours before your appointment.
(You should send in pages 2-9)
Healthy regards,

Kathryn Fink, MS, RDN, LD, CEDRD

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The initial 1 hr. Nutritional Assessment and Consultation is $200. Follow-up therapy sessions are $125.00 per 30-45 minutes. Phone nutrition therapy is $50 per quarter hour segment (6-15 minutes). Package sessions may be offered to families to assist in improving your health. Payment is due at the time of the office visit. Cash, checks and credit cards are accepted. There is a $35.00 charge for returned checks.

When medical nutrition therapy and weight management is prescribed by a physician or you have an eating disorder diagnosis from a physician, you may be able to apply health savings dollars or be reimbursed by your insurance. We will provide a special receipt that you may present to your insurance company for reimbursement.

Again, welcome to my practice. I look forward to helping you reach *your* goals.
Kathryn Fink, Registered/Licensed Dietitian

I have read and understand the information about services and policies. I understand that I may have a copy for future reference if requested. I agree to be responsible for all charges for myself/spouse/child/children.

_____ _____
Signature Date/Year

_____ _____
Guardian Signature Date/Year

CANCELLATION POLICY

If you are unable to keep a scheduled appointment, please leave a message on my voice mail (214-850-9573) at least 24 hours in advance to avoid being charged for the time reserved for you. Your appointment time is reserved for you and cannot be booked by other clients. If you are unable to cancel your appointment at least 24 hours in advance, you will be charged $100 for your missed appointment.
Please provide your credit card number, only to be used on missed appointments

_____
Expiration date_____ Circle card Mastercard Discover Visa
3 digit code on back of card_____ zip code with card _____

_____ _____
Signature Date/Year

_____ _____
Guardian Signature Date/Year

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HEALTH CARE TEAM COMMUNICATION AND RECORDS RELEASE

RECORDS RELEASE

We will be happy to send a progress note to your physician or therapist to facilitate a more unified approach to your care. Your signature below is your consent for me to release or receive specific information to the following relative to treatment and/or assessment. Please fill in the name of your

Therapist_____
Address _____
Phone_____
Fax _____

Treatment Center_____
Address _____
Phone_____
Fax _____

Psychiatrist_____
Address _____
Phone_____
Fax _____

Physician(s)_____
Address _____
Phone_____
Fax _____

Physician(s)_____
Address _____
Phone_____
Fax _____

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. I understand that the specified information information to be released may include but is not limited to history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

Patient Signature_____ Date_____
Guardian Signature _____ Date_____
Please mark here if you would like me to send a summary letter to the above___

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COMMUNICATION PRIVACY

Please list contact phone numbers and emails you would like for us to use regarding your nutrition appointments. This will be used if needed to confirm an appointment or change a scheduled time to due to an emergency or illness of the dietitian. Note the email does not use encryption and is not secure. Please list information of locations you want me to use.

Home # _____ Work# _____ Cell #_____
Address:_____ City:_____ Zipcode:_____
Email address: _____
Can I contact through mail:_____ Email:_____ Phone:_____

I am agreeing to being contacted at the numbers and/or email provided above.
Please list any privacy guidelines you would like us to specifically respect:
_____
_____
Patient Signature_____ Date _____
Guardian Signature _____ Date_____

Patient Information

Patient Name:_____ Date of Birth:_____
Primary Physician _____ Date of last checkup_____
Has a physician prescribed a diet for you?_____ If yes, what? _____
How did you hear about our service ?_____
Reason for referral to this office?_____
_____
How long have you had this condition/disease?_____
Under other physician' care? Y N If so, who and what?_____
_____

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Weight/Diet History

Height _____Usual Weight_____ Highest Weight_____ When?___
Lowest Weight_____ When?___ Recent Weight Change?_____
If so, please elaborate_____
When did the weight problem start?_____
Is anyone in your family overweight? Y N If so, who?_____
Please give as much detail as possible on your dieting history (which ones, what you liked about each one, didn't like about each one and how much weight lost & gained back)

Diet	Liked +	Did not like -	Weight lost	Weight Gained	Dates

Use additional pages as necessary

What other types of techniques have you tried to lose/maintain/gain weight?_____
_____

Personal Medical History:

___Heart disease or stroke ___Obesity ___Anemia
___High blood pressure ___Arthritis ___Depression
___Hyperlipidemia ___Dentures ___Mental illness
___Thyroid ___Chewing problems ___hypoglycemia
___Hormone ___Constipation ___Major Surgery
___Cancer ___Diarrhea ___Surgeries
___Lung problems ___Food sensitivities(list below) ___Physical handicap
___Ulcers ___Food allergies(list below) ___Other allergies
___Gastrointestinal disorder ___Diabetes ___Other

Please provide any additional info that would be helpful for your assessment below…

Family Medical History:

___Heart disease or stroke ___Obesity ___Anemia
___High blood pressure ___Arthritis ___Depression
___Hyperlipidemia ___Diabetes ___Mental illness
___Thyroid ___Chewing problems ___hypoglycemia
___Hormone ___Constipation ___Major Surgery
___Cancer ___Diarrhea ___Surgeries
___Lung problems ___Ulcers ___gastrointestinal disorder
___Other

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Social history
Alcohol: _no _few drinks/yr__few drinks/month __1-4/week__≥1 /day
Smoking: __no __ex __cigars __pipe __cigarettes __smokeless tobacco
Overeating: __no __occasional __when hungry __insatiable __day __night
Last dental office visit____(date)
Do you drink coffee?____ tea? _____ regular soda?____ diet soda?____water? _____
If so, what and how much per day/week?_____
_____ _____ _____
Tire easily: __no __yes
Identify your stress level : High Moderate Low

Activity
Regular exercise program: (times per week)____ Describe type of exercise_____
Length of exercise sessions _____ minutes/hours

PAR-Q=Physical Activity Readiness Test Questions:

For most people, physical activity should not pose any problem or hazard. The PAR-Q has been designed to identify the small number of adults for whom physical activity might be inappropriate or those who should have medical advice concerning the type of activity most suitable for them.
Has your doctor ever said you have heart trouble?
Y N
Do you frequently suffer from pains in your heart or chest?
Y N
Do you often feel faint or have spells of severe dizziness?
Y N
Has a doctor ever said your blood pressure was too high?
Y N
Has your doctor ever told you that you have a bone or joint problem such as arthritis that might be made worse by exercise or has been aggravated by exercise? Y N
Is there a good physical reason not mentioned here why you should not follow an activity program even if you wanted to? Y N
Are you over 65 and not accustomed to vigorous exercise?
Y N
If you answered yes to any of the above questions, please refer to a physician for medical clearance before starting any exercise program.

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Current Medications:

Name	Amount	Time of Day	Purpose	Side Effects?

Current Vitamins/Minerals/Herbs:

Name	Amount	Time of Day	Purpose	Side Effects?

Latest lab results (cholesterol, HbA1c, recent blood sugars, please bring copies or send them in with your paperwork):
Date of most recent numbers:_____
Total Cholesterol _____ LDL _____ HDL_____ Triglycerides_____
Blood pressure_____
Blood glucose_____
Other _____
Are your menstrual periods regular? Y N N/A Are you trying to get pregnant Y N N/A
Have you ever used laxatives, water pills or vomited for weight control? Y N
Do you ever feel guilty after eating? Y N
Do you skip meals? Y N If so, which meal/meals?_____
Do you snack? Y N If so, when and what?_____
Do you eat standing up? Y N Do you eat in your car? Y N
Do you eat at the dinner table? Y N Do you eat while watching the tv? Y N
Where do you eat most of your meals?_____
Do you eat when preparing foods or storing leftovers?_____
What % of your meals are prepared at home?_____%
When eating meals prepared outside of the home, where are they usually from?
_____
Who does the shopping in your household?_____
Do you read food labels? Y N If so, what do you look for?_____
Is there another person in your household on special diet? Y N

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Please write down everything you have eaten and drank in the last 24 hours, including

time	measurement	food item
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Any additional information you wish to share or feel is helpful for me to know.

_____
_____
_____
_____
_____
_____
_____
_____
_____

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HIPAA/DISCLOSURE FORM

By my signature below, I understand that while some insurance companies pay for a percentage of this service, I am responsible for the services at time service is provided. I will be provided with a receipt that I can submit to my insurance company for reimbursement.

By my signature below, I acknowledge that I have been provided with an opportunity to read the HIPAA policy (attached) and understand that while some insurance companies pay for a percentage of this service, I am responsible for the services at time service is provided. I will be provided with a receipt that I can submit to my insurance company for reimbursement.

In addition, I acknowledge and agree that I have disclosed, or will disclose upon request, full, accurate and complete information regarding my dietary and medical history, medical conditions, all diagnoses by any physician, all known allergies, and the identity of all prescription and non-prescription medications which I take. I understand that the effectiveness and applicability of the dietary guidance and advice I receive from Kathryn Fink may be affected by my failure to disclose the information noted above, or may potentially create other health risks.

_____	_____	_____
Print Name	Signature	Date

Guardian Signature _____ Date_____

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HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date*: *April 2003

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.
If you have any questions about this notice, please contact:
Kathryn Fink, MS, RD, LD
2701 Wallin Dr
Irving, TX 75061
214-850-9573

OUR PLEDGE REGARDING PROTECTED HEALTH INFORMATION:
We Kathryn Fink MS, RD, LD understand that protected health information about you and your health is personal. We are committed to protecting health information about you. This Notice applies to all of the records of your care generated by the Kathryn Fink, RD, LD, whether made Kathryn Fink MS, RD, LD personnel or your personal doctor. This Notice will tell you about the ways in which we may use and disclose protected health information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of protected health information. The law requires us to:

- make sure that protected health information that identifies you is kept private;
- notify you about how we protect protected health information about you;
- explain how, when and why we use and disclose protected health information;
- follow the terms of the Notice that is currently in effect.

We are required to follow the procedures in this Notice. We reserve the right to change the terms of this Notice and to make new notice provisions effective for all protected health information that we maintain by:

- posting the revised Notice in our office
- making copies of the revised Notice available upon request;
- posting the revised Notice on our Web site.

HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU.
The following categories describe different ways that we use and disclose protected health information without your written authorization.
For Treatment. We may use protected health information about you to provide you with, coordinate or manage your medical treatment or services. We may disclose protected health information about you to doctors, nurses, technicians, medical students, or other Kathryn Fink MS, RD, LD personnel who are involved in taking care of you. Kathryn Fink MS, RD, LD staff may also share protected health information about you in order to coordinate the different things you need, such as prescriptions, lab work and x-

rays. We also may disclose protected health information about you to people outside Kathryn Fink, MS, RD, LD who may be involved in your medical care, such as clergy or others we use to provide services that are part of your care.
We may use and disclose protected health information to contact you as a reminder that you have an appointment for treatment or medical care at the Kathryn Fink MS, RD, LD.
We may use and disclose protected health information to tell you about or recommend possible treatment options or alternatives or health-related benefits or services that may be of interest to you.
For Payment for Services. We may use and disclose protected health information about you so that the treatment and services you receive at the Kathryn Fink MS, RD, LD may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about nutrition services you received at Las Colinas Medical Center so your health plan will pay us or reimburse you for the service. We may also tell your health plan about the nutrition services you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.
For Health Care Operations. We may use and disclose protected health information about you for Kathryn Fink MS, RD, LD health care operations, such as our quality assessment and improvement activities, case management, coordination of care, business planning, customer services and other activities. These uses and disclosures are necessary to run the facility, reduce health care costs, and make sure that all of our patients receive quality care.
For example, we may use protected health information to review our treatment and services and to evaluate the performance of the dietitian who is providing your services. We may also combine protected health information about many Kathryn Fink MS, RD, LD patients to decide what additional services the Kathryn Fink MS, RD, LD should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, and other Kathryn Fink MS, RD, LD personnel for review and learning purposes. We may also combine the protected health information we have with protected health information from other health care facilities to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of protected health information so others may use it to study health care and health care delivery without learning who the specific patients are. We may also contact you as part of a fundraising effort.
Subject to applicable state law, in some limited situations the law allows or requires us to use or disclose your health information for purposes beyond treatment, payment, and operations. However, some of the disclosures set forth below may never occur at our facilities.
As Required By Law. We will disclose protected health information about you when required to do so by federal, state or local law.
Research. We may disclose your PHI to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information
Health Risks. We may disclose protected health information about you to a government authority if we reasonably believe you are a victim of abuse, neglect or domestic violence. We will only disclose this type of information to the extent required by law, if

you agree to the disclosure, or if the disclosure is allowed by law and we believe it is necessary to prevent or lessen a serious and imminent threat to you or another person.
Judicial and Administrative Proceedings. If you are involved in a lawsuit or dispute, we may disclose your information in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made, either by us or the requesting party, to tell you about the request or to obtain an order protecting the information requested.
Business Associates. We may disclose information to business associates who perform services on our behalf (such as billing companies) however, we require them to appropriately safeguard your information.

Public Health. As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.
To Avert a Serious Threat to Health or Safety. We may use and disclose protected health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
Health Oversight Activities. We may disclose protected health information to a health oversight agency for activities authorized by law. These activities include audits, investigations, and inspections, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.
Law Enforcement. We may release protected health information as required by law, or in response to an order or warrant of a court, a subpoena, or an administrative request. We may also disclose protected health information in response to a request related to identification or location of an individual, victims of crime, decedents, or a crime on the premises.
Organ and Tissue Donation. If you are an organ donor, we may release protected health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.
Special Government Functions. If you are a member of the armed forces, we may release protected health information about you if it relates to military and veterans activities. We may also release your protected health information for national security and intelligence purposes, protective services for the President, and medical suitability or determinations of the Department of State.
Coroners, Medical Examiners, and Funeral Directors. We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose protected health information to funeral directors consistent with applicable law to enable them to carry out their duties.
Correctional Institutions and Other Law Enforcement Custodial Situations. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release protected health information about you to the correctional institution or law enforcement official as necessary for your or another person's health and safety.

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Worker's Compensation. We may disclose information as necessary to comply with laws relating to worker's compensation or other similar programs established by law.
Food and Drug Administration. We may disclose to the FDA, or persons under the jurisdiction of the FDA, protected health information relative to adverse events with respect to drugs, foods, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.
YOU CAN OBJECT TO CERTAIN USES AND DISCLOSURES
Unless you object, or request that only a limited amount or type of information be shared, we
may use or disclose protected health information about you in the following circumstances:

- We may share with a family member, relative, friend or other person identified by you protected health information directly relevant to that person's involvement in your care or payment for your care. We may also share information to notify these individuals of your location, general condition or death.
- We may share information with a public or private agency (such as the American Red Cross) for disaster relief purposes. Even if you object, we may still share this information if necessary for the emergency circumstances.

If you would like to object to use and disclosure of protected health information in these circumstances, please call or write to our contact person listed on page 1 of this Notice.
YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU.
You have the following rights regarding protected health information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy protected health information that may be used to make decisions about your care. Usually, this includes medical and billing records.
To inspect and copy protected health information that may be used to make decisions about you, you must submit your request in writing *to* Kathryn Fink MS, RD, LD If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request, and we will respond to your request no later than 30 days after receiving it. There are certain situations in which we are not required to comply with your request. In these circumstances, we will respond to you in writing, stating why we will not grant your request and describe any rights you may have to request a review of our denial.
Right to Amend. If you feel that protected health information we have about you is incorrect or incomplete, you may ask us to amend or supplement the information.
To request an amendment, your request must be made in writing and submitted Kathryn Fink MS, RD, LD. In addition, you must provide a reason that supports your request.
We will act on the your request for an amendment no later than 60 days after receiving the request.
We may deny your request for an amendment if it is not in writing or does not include a reason to support the request, and will provide a written denial to you. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;

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- Is not part of the protected health information kept by Kathryn Fink MS, RD, LD
- Is not part of the information which you would be permitted to inspect and copy; or
- We believe is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of protected health information about you.
To request this list or accounting of disclosures, you must submit your request in writing to Kathryn Fink MS, RD, LD. You may ask for disclosures made up to six years before your request (not including disclosures made before April 14, 2003). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We are required to provide a listing of all disclosures except the following:

- For your treatment
- For billing and collection of payment for your treatment
- For health care operations
- Made to or request by you, or that you authorized
- Occurring as a byproduct of permitted use and disclosures

- For national security or intelligence purposes or to correctional institutions or law enforcement regarding inmates
- As part of a limited data set of information that does not contain information identifying you

Right to Request Restrictions. You have the right to request a restriction or limitation on the protected health information we use or disclose about you for treatment, payment or health care operations or to persons involved in your care.
We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment, the disclosure is to the Secretary of the Department of Health and Human Services, or the disclosure is for one of the purposes described on pages 4-5.
To request restrictions, you must make your request in writing to Kathryn Fink MS, RD, LD.
Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.
To request confidential communications, you must make your request in writing to Kathryn Fink, RD, LD. We will accommodate all reasonable requests.
Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice at any time by contacting Kathryn Fink MS, RD, LD
OTHER USES AND DISCLOSURES
We will obtain your written authorization before using or disclosing your protected health information for purposes other than those provide for above (or as otherwise permitted or required by law). You may revoke this authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your information, except to the extent that we have already taken action in reliance on the authorization.

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YOU MAY FILE A COMPLAINT ABOUT OUR PRIVACY PRACTICES

If you believe your privacy rights have been violated, you may file a complaint with Kathryn Fink MS, RD, LD or file a written complaint with the Secretary of the Department of Health and Human Services. A complaint to the Secretary should be filed within180 days of the occurrence or action that is the subject of the complaint.

If you file a complaint, we will not take any action against you or change our treatment of you in any way.