3905 Johns Creek Court, Suite 260, Suwanee, GA 30024
(770) 753-0350 office (770) 497-9536 fax

Paraclete Counseling Center, Inc. offers biblically sound, psychologically competent professional counseling for individuals, couples, families and groups. Topical seminars and workshops, and consultations are also available. In addition, we have a dietitian on staff who provides nutrition counseling as an adjunct service in overall well-being.

Counseling and nutrition therapy are cooperative ventures with responsibility resting on both the counselor and the client. In order for us to work most effectively together, please carefully read the information below and discuss any concerns with me during your first session.

Informed Consent for Nutrition Services

Mary Ann Woodward is a Licensed Associate Professional Counselor and Registered Dietitian. She earned a B.S. from Miami University in 2000, and completed her dietetic internship at Medical University of South Carolina in 2001. She is a Licensed Dietitian in the state of Georgia and also holds an M.A. in Professional Counseling with a specialization in Child and Adolescent Counseling from Psychological Studies Institute. Her training has prepared her to specialize in treating individuals with eating disorders and related problems. However, she also treats a variety of other nutrition-related problems, including but not limited to diabetes management, GI problems, hypertension, obesity and perinatal issues.

If you are in need of nutrition services only, emotional and psychological issues will not be explored in depth. If you are seeing another therapist separately, she will refer you to him or her to explore such issues and protect the established therapeutic relationship. Consultations will be made with your therapist only upon your authorized consent (separate form).

CONFIDENTIALITY:

All information shared between dietitian and client is confidential and will not be revealed unless required by law in such cases of suspected child abuse or threats of physical harm to self or others. In order to give high quality treatment, I sometimes consult with other professionals about my clients, while protecting their identity. The same rules and laws that I am bound by also bind these professionals in order to protect your confidentiality.

IMPORTANT EXTENSIONS:

Mary Ann Woodward	103
Kim Hart/Operator	101 or 0
Directions to Office	Option 4
Office Address & Fax #	Option 5

PAYMENTS AND BILLING:

Nutrition Therapy Sessions: The initial nutrition assessment lasts 60 minutes. Follow-up sessions may be 30 or 60 minutes in length depending upon your needs. If you require a longer session, it will be prorated based on the stated fee. Any client who has a balance of fees for more than two sessions will be unable to continue treatment until your payment is made. Individual exceptions can be made. If you are unable to pay these fees, please discuss other arrangements with me directly. In the event that we are unable to collect fees owed by you, we reserve the right to use an outside collection agency to work on our behalf to collect overdue balances.

Initial Nutrition Assessment	$100
60-minute Follow-Up Sessions	$100
30-minute Follow-Up Sessions	$50

Cancellation of Appointment: If you must cancel your appointment, please call the office and leave a message at extension 103. **You must cancel at least 24 hours in advance of your scheduled appointment.** If you do not cancel your appointment 24 hours in advance, you will be charged our standard fee, not your co-pay. Insurance does not cover late cancellations or no shows. Exceptions will be made in case of illness or other emergency.

Telephone Consultations: I understand that at times telephone consultations are necessary. If a conversation last over 10 minutes, please see the fee breakdown below.

10-20 minutes	20-30 minutes	30-40 minutes
$25	$35	$45 and up

Reports: I will not charge you for my time spent making simple reports to your insurance company. However, any reports needed for other professionals, including but not limited to lawyers, medical doctors, and therapists, will be charged a fee as stated below.

20-30 minutes	30-40 minutes	40-50 minutes
$25	$50	$75

Returned Checks: You will be assessed a $20 fee for checks returned with insufficient funds.

I have read and understand the conditions and information above and agree to these conditions. A parent or legal guardian's signature is required for clients under the age of 18.

Signature ____ Date _____

Relationship to client (if under 18) ______________________________________

A copy of this form will be kept in your confidential file. If you wish to have a copy for your records, please request one.

Confidentiality and Managed Care

Your managed care plan (MCP) chosen by your employer may include nutrition services, but will set limits on both you and your dietitian. I am not contracted with any managed care companies, but you may be able to be reimbursed through out of network benefits. If you choose to access treatment through your MCP, you need to be aware that the plan will be involved in direct clinical management of your case. I will be required to give extensive and sensitive information about you and your case to the MCP. This information is used by the plan for determining benefits, which they allocate at their own discretion. This impacts your right of confidentiality, and it is possible that your information will be put into a computer system that could be accessed by anyone. The MCP will decide how many sessions I can provide to you and can even refuse to allow me to treat you. It can refuse to pay for *any* of your treatment, or may pay only a very small part of its cost. Finally, it can limit the kinds of treatments I can provide to you.

Even if it does give the "go-ahead" to treatment, the MCP may put limits on the number of times we can meet. Your insurance policy probably has a maximum number of appointments allowed for nutrition therapy, if allowed at all, but the MCP does not have to let you use all of those appointments. Also, it may not agree to more sessions even if I believe we need more to fully relieve your problems, or even if I think that undertreating your problems may prolong your pain or lead to backsliding. If the MCP denies payment before either of us is satisfied about our progress, we may also need to consider other treatment choices, which may not be the ones we would prefer.

We can appeal the MCP's decisions on payment and number of sessions, but we can only do so within the MCP itself. We cannot appeal to other professionals, to your employer, or through the courts without great effort. You should know that your employer's contract with a particular MCP may prevent us from taking actions against it if things go badly because of its decisions.

If after reading this and discussing it with me, you are concerned with these issues, you have the choice of paying me directly and not using your health insurance. This will create no record outside of my files. Direct payment provides you with confidentiality.

I have read and understood the issues described above and willingly enter treatment accepting these limits. I give my therapist permission to submit information in order to secure payment for the nutrition services to be provided to me.

____ ____________________

Signature of client Date

revised 5/2008

This form will become a part of your confidential file. Please answer each question as completely as possible.

Date________________________________

PART I: CLIENT

Name____ Age _______Sex _____
First Middle Last
Address____

____
City State Zip

Home Phone ___________________ Work Phone ___________________________

Pager_____________________________ Cell Phone ________________________

Date of birth ______________________ email address: _________________________

Marital Status: Single ______ Married ______ (# of years _____) Divorced ________

Occupation_____________________________ Total hours/week_______________

Employer (or school) ________________________________ Full-time Part-time

Address of employer ____

Family member to notify in case of emergency ______________________________

Emergency contact phone number ____

Who gave you my name? ____

May I have your permission to thank this person for your referral? Yes No

Part II: Health History Information

Primary Care Physician (PCP) ____

Address _____________________________________ Phone ________________

Please list any over-the-counter medicines or prescribed medicines you are taking currently (herbs, supplements, etc.), including the dosages ____

____

Please list any medical conditions which have been previously or currently diagnosed.
Condition Date Diagnosed Doctor

___

___

___

Please list any history of physical or mental health conditions which required hospitalization.
Year Reason Hospital

___

___

___

Do you have any food or drug allergies? ___ Yes ___ No If yes, please list.

___

___

Please list any family history of significant health problems, including obesity and eating

disorders. ___

___

Please check the space which most accurately describes your exercise habits.

___ Sedentary (No regular exercise)

___ Minimal exercise (15-30 min. 3x per week)

___ Moderate exercise (30 min. 3-4x/week

___ Strenuous exercise (30-60 min. >4x/week)

Are you dieting? ___ Yes ___ No

If yes, are you on a physician prescribed medical diet? ___ Yes ___ No

How many meals do you eat in an average day? ___________

Have there been any recent changes in your appetite or eating habits? ___ Yes ___ No
If yes, please describe.

___

Has your weight fluctuated more than 10 lbs. over the previous year? ___ Yes ___ No

Do you often eat out of boredom, depression and anger? ___ Yes ___ No If yes, please describe. ____

Do you ever self-induce vomiting? ___ Yes ___ No If yes, how often? ________________________

Do you ever binge eat or feel your eating is out of control? ___ Yes ___ No If yes, please describe. ____

Please describe if you have any digestive problems such as diarrhea, constipation, gas, pain, etc.

____

If you use laxatives, diuretics or diet pills, how often do you use them? __________________________

Please describe your typical caffeine consumption. ____

Do you drink alcohol? ___ Yes ___ No If yes, what kind? __________________________________

How many drinks per week? ________ Do you see your current usage as a problem? ______________

Are you prone to “binge” drinking? ___ Yes ___ No

If applicable, please describe your tobacco use. ____

Do you currently use any recreational or street drugs? ___ Yes ___ No

Mental Health

Would you consider stress a major problem for you? ___ Yes ___ No

Do you often feel depressed? ___ Yes ___ No

Have you ever attempted suicide ___ Yes ___ No

Have you ever seriously considered hurting yourself? ___ Yes ___ No

Do you have trouble sleeping? ___ Yes ___ No Number of hours _____________

Women Only

Age at onset of menstruation: _______ Date of last menstruation: ________________

Period every _____ days

Please describe any irregularity with periods or discharge. ______________________________________

Number of pregnancies _____ Number of live births _____

Are you currently pregnant or breastfeeding? ___ Yes ___ No

PART III: FINANCIAL INFORMATION

If you have any financial questions or concerns about your fee, please discuss them with me. Fees or co-pays are due at time of service. You may use cash, check, debit card, Visa, MasterCard or Discover.

Total gross family income ____________________ # of dependents_____________

Who is financially responsible for these fees? ________________________________

Do you have insurance? ____

I am not on any network panels but can accept insurance through out-of-network benefits. Do you have out-of-network benefits for outpatient nutrition services? __Yes __No __Not sure

ALL BLUE CROSS/BLUE SHIELD CLIENTS MUST FILE THEIR OWN CLAIMS

Primary Insurance Company ____

Address ____

Phone Number of Insurance Company _____________________________________

Policy #__________________ Group # ___________________________________

Insured's Name __________________________ Insured's SS# __________________

Insured's Date of Birth ____

Insured's Employer ____

I, the undersigned, do authorize the release of any medical information necessary to process claims. I hereby assign payments directly to Paraclete Counseling Center and the supervisors thereof of the benefits as well as major medical benefits herein specified, and otherwise payable to me under the terms of my insurance. I understand that I am financially responsible to the clinician for charges not covered by this agreement. I hereby authorize photocopies of this form to be as valid as the original. Signed this _____ day of ____________________, 20_____; in the city of ________________________, situated in ____________________ county, state of Georgia.

Signed____ Date ____________