Angela Lovell, MAPC, RDN, LD
10,000 N Central Expy, Suite 471
Dallas, TX 75231
Office (972) 762-0176
Fax (972) 476-1097
www.nutritiontherapyandwellness.com

Client Agreement

Patient Name _____ Date of Birth _____

↓ Initial

_____ **Insurance:** I authorize Nutrition Therapy and Wellness to release information to my insurance companies and to be paid directly by my insurance companies for services billed. I understand that it is my responsibility to know what my insurance plan covers, whether or not a referral or pre-authorization is required and if there are any limitations of coverage (number of allowed visits, covered diagnoses, etc). If claims are denied for any reason, I acknowledge that I am responsible for the full amount billed to insurance and the below credit card will be used with a superbill and receipt emailed to the below address.

_____ **HIPAA**: I have received a Notice of Privacy Practices explaining the Health Insurance Portability and Accountability Act (HIPAA).

_____ **Cancellation Policy**: I agree to pay $75 for missed appointments and agree to have the below credit card charged if I do not call (972) 762-0176 at least 24 hours prior to my appointment to cancel or reschedule. This charge is irrespective of the reason for the cancellation/ no show and is not covered by insurance. If there is a pattern of cancelled appointments (whether providing 24 hrs notice or not), I understand that I may be denied future services.

_____ **Payment**: I understand that all co-payments and other self-pay fees are due at time of service. Returned checks will incur a flat $40 fee. Balances unpaid after 90 days may be sent to collections. If it becomes necessary to effect collections of any amount owed, I agree to pay all costs and expenses, including reasonable attorney fees.

_____ **Card on File:** I authorize Nutrition Therapy and Wellness to keep my credit card securely on file and charge it for all fees owed, including appointment fees, supplements, lab tests, no show/late cancel fees and any others. If for any reason my card is declined, I agree to immediately send payment for all balances owed.

Card Number _____ - _____ - _____ -_____ Expiration _____/_____
Name on Card _____ CVV _____
○ Visa ○ MasterCard ○ Debit:_____

Your signature below indicates that you have read this policy and agree to its terms.

Patient Signature _____ Date _____

Responsible Party for minors under the age of 18:
Signature _____ Date _____

Printed Name _____ Relationship _____

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My Practice and Credentials

I provide nutritional counseling and medical nutrition therapy to preteen through adult clients seeking to improve their health and/or prevent future health problems through food and lifestyle modifications. I am uniquely qualified to assist each client with dual credentials in nutrition and professional counseling. I provide individualized nutrition counseling with ongoing communication between sessions to ensure you reach your nutrition and wellness goals. With over fifteen years of experience in nutrition counseling, I continue to dedicate my time in establishing the best individual care for each client. My professional credentials are listed below.

Angela Lovell, MAPC, RDN, LD

- Master of Arts in Professional Counseling
- Registered Dietitian Nutritionist, #950022
- Licensed Dietitian in Texas, #DT80621

Appointments & Communication

When you arrive, I may be in session with another client. Please let the receptionist know you are here to see me and then have a seat in the lobby or help yourself to a beverage in the café. I will come get you from the lobby area. If you are late to your appointment, the lost time will not be added to the end of your scheduled time. Appointments may be booked online through my website. As a courtesy, my scheduling system will send an email reminder the day before your appointment. In most cases, clinical issues should be reserved for appointments. For non-urgent issues regarding appointments, scheduling, or billing, you may email me at angela@nutritiontherapyandwellness.com. Please allow two business days for a response.

Insurance

I am contracted with Blue Cross Blue Shield of Texas insurance plans. Please visit my website for a complete list of the insurances I accept, and for help with determining what your plan covers. If I am not contracted with your insurance, I will upon request provide you with a form called a “superbill” that you can send in to them for possible reimbursement under your out-of-network benefits.

Service Fees

Current rates are posted on my website and are subject to change at any time. I offer reduced rates for patients without insurance benefits when payment is made in full at the time of service. Additional savings can be had when purchasing an appointment package. Packages are valid for 6 months from date of purchase. No refunds will be given for unused visits.

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Nutrition Therapy & Wellness

INTAKE FORM

Name:_____ DOB/Age:_____ Date:_____
Address:_____
Phone (cell)_____ Email_____ Preferred contact_____
Describe your recent eating and digestion history that brought you here_____
_____
_____
_____
Height:_____ Current Weight:_____ Lowest Weight: _____ When:_____
Highest Weight:_____ When:_____ "Comfortable" Weight:_____ When:_____
Have you been able to maintain your "comfortable" weight for any period of time? Yes _____No_____
If yes, how long? _____ How often do you weigh yourself?_____
When was your last physical?_____
Have you ever had any abnormal bloodwork results? Yes_____ No_____ If yes, please list or bring abnormal tests:_____
Do you have any significant family medical history? Yes_____ No_____ If yes, please list here:
_____
_____
Check any of the following medical/physical issues that currently apply to you:
Low energy levels ___ Bloating/edema___ Constipation___ Diarrhea ___ Dental Problems ___
Insomnia ___ Reflux___ Gas___ Diabetes (high blood sugar) ___ Low blood sugar_____ Headaches___
Light headedness___ Cold sensitivity___ Bruise easily___ Muscle Cramps___ Hair Loss___ Increased hair on skin___ Insulin resistance___ High Blood pressure___ Other:_____
Please list any other medical or psychiatric diagnoses:_____
_____ _____
Have you started menstruation? Yes___ No___ If so, have you ever lost a cycle?_____
At what weight approximately did you start menstruating? _____lbs. What age?_____
Please list any nutritional supplements (including vitamins, minerals, herbals):_____
_____
Current medications:_____
_____
Have you ever or are you currently participating in the following behaviors?
Describe your last disordered eating behavior/s (Food, amount, time of day, place, hunger, emotions, anxiety level, other):_____
_____
Bingeing? Yes___ No___ Last Time:_____ Frequency: ____x/week
Vomiting following food intake? Yes___ No ___ Last Time:_____ Frequency _____x/week
Laxative (or enema) abuse? Yes___ No___ Last Use:_____ Frequency_____ x/week
What type?_____
Use of diet pills (or diuretics)? Yes___ No___ Last Use: _____ Frequency ____x/week
Restricting calories? Yes___ No___ Current calorie level_____ Current eating plan_____
Which foods are you currently restricting?_____
_____
Please list any diet, low-fat or fat-free foods or condiments you consume, when, and how much:
_____
Food allergies, or foods you have never liked _____
Any history of compulsive exercise? Y___ N___ Please describe your current exercise routine_____
_____
With whom do you currently live?_____

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INTAKE FORM

Who does most of the grocery shopping? _____ Planning?_____ Cooking?_____
How many times per week do you normally dine out?_____
What types of restaurants and what types of entrée choices do you normally make?
_____
Do any members of your family have weight issues? (i.e. obesity, eating disorders) Yes___ No ___
If yes, who?_____
Does your family sit down for family meals? Yes___ How often/where?_____ No___
What obstacles do you face when trying to change your relationship with food and/or your nutritional intake?_____
_____
Please provide any other information in the space below regarding your eating habits that you feel we should be made aware of while you're here (e.g. any other food fears or rituals here):
_____
_____
_____

This section will be completed during your initial session

Dx:_____Ht:_____ Wt:_____ IBW (+/- 10%):_____ % IBW_____
BMI_____ Growth %ile for Wt_____ Wt Range Goal:_____ Est. Current Calorie Intake_____ Estimated Calorie needs_____ Nutrition Concerns/Plan: Wt Gain:_____ Maintenance_____
Goals to improve relationship with food:_____
Nutrition Counseling plan of care for initial and future sessions:
_____
_____
_____

Angela Lovell, MAPC, RDN, LD Signature:_____
CPT/ICD10 Codes:_____
Date:_____