Informed Consent, Policy and Waiver Form

Big Picture Health LLC, Personalized Nutrition by Tracey Long, MPH, RDN

Please read and initial each section then sign and date the bottom of the form.

AUTHORIZATION FOR CARE/ INFORMED CONSENT

I/we voluntarily consent to receive personalized nutrition services at Big Picture Health LLC. I certify that neither Big Picture Health LLC nor any of its representatives has made any guarantee to me as to the results to be obtained utilizing the above described services.

I understand that the services provided by Big Picture Health LLC are for the purpose of promoting health, preventing illness or injury, or reducing risks and are not considered treatment for any specific illness or disease. For the treatment of a specific illness or disease, Big Picture Health LLC recommends that I maintain a relationship with and seek services from my primary care physician. Please acknowledge consent with full knowledge of the nature, risks, and purpose of the evaluation and treatment program with your initials below.

INITIAL: ☐

ATTENDANCE POLICY

It is my pleasure to provide integrative and functional medical nutrition therapy services at Big Picture Health LLC. In the event you are unable to keep a scheduled appointment or participate in your program, you are to notify me prior to the scheduled appointment or program time. If two consecutive absences occur without notification from you for the reason for absence, services will be discontinued secondary to non-compliance in respect to attendance. **Advance notice of 24 hours is requested if you are not able to keep an appointment. If you no show or cancel an appointment in less than 24 hours, you will be at charged full session price.**

INITIAL: ☐

PAYMENT POLICY

I understand that all services provided through Big Picture Health LLC are considered "alternative medicine" services and are not covered by Medicare, Medicaid, or other traditional health insurance plans. I understand that Big Picture Health LLC will not submit a claim to my insurance company and I am responsible for payment for services in full at the time of service. Packages are non-refundable. I understand that Big Picture Health LLC cannot answer my insurance questions, will not become involved in any dispute with my insurance company, and will not falsify documentation or billing in an attempt to satisfy coverage criteria. IN THE EVENT A CHECK IS RETURNED FOR ANY REASON, A $25.00 CHARGE WILL BE MADE TO MY ACCOUNT. I AGREE TO PAY ALL COSTS AND EXPENSES, INCLUDING REASONABLE ATTORNEYS' FEES, INCURRED IN THE COLLECTION OF PAST DUE ACCOUNTS. Amounts turned over for collection will be subject to 25% collection fee. The parents (or guardians) accompanying a minor are responsible for payment of the minor's treatment.

INITIAL: ☐

WAIVER OF LIABILITY

I am sufficiently physically fit to participate in nutrition services available at Big Picture Health LLC. I understand that it is my responsibility to consult with a physician regarding any recommended dietary changes or use of nutritional supplement and that Big Picture Health LLC recommends I consult with my other health care providers prior to implementing nutritional service recommendations. I will participate in all nutrition services at my own risk. I understand that in participating in the nutrition programs at Big Picture Health LLC there is a possibility of injury, including, but not limited to, allergic reaction or side effect of dietary change or nutritional supplement. I AGREE TO ASSUME THE RISK OF SUCH INJURY AND TO RELEASE, WAIVE, AND DISCHARGE BIG PICTURE HEALTH LLC, TRACEY LONG, AND ANY MEMBERS, OFFICERS, DIRECTORS, SHAREHOLDERS, PARTNERS, EMPLOYEES, CONTRACTORS, PERSONNEL, OR AGENTS OF BIG PICTURE HEALTH ("RELEASEES"), FROM LIABILITY FOR ANY AND ALL INJURY, ILLNESS, HARM OR DAMAGE, INCLUDING, BUT NOT LIMITED TO ALLERGIC REACTION OR SIDE EFFECT FROM DIETARY CHANGE OR NUTRITIONAL SUPPLEMENT, OCCURRING IN CONNECTION WITH MY RECEIPT OF SERVICES FROM RELEASE.

INITIAL: ☐

By signing below, I acknowledge that I have read and agree with Big Picture Health LLC, Personalized Nutrition's Authorization of Care/ Informed Consent, Attendance Policy, and Payment Policy.

Client Name: _____ **Date of Birth:** _____

Signature: _____ **Today's Date:** _____

☐ **I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above Terms.**

If Client is a minor, to be signed by Parent or Guardian

Printed Name of Parent or Guardian: _____

HIPAA Email Consent

PLEASE READ CAREFULLY AND SIGN BELOW (Select either Option 1 or Option 2)

- HIPAA stands for Health Insurance Portability and Accountability Act
- HIPAA was passed by the U.S. Government in 1996 in order to establish privacy and security protections for health information
- Health information stored on my computer is held behind a highly secure password and is stored in backup files on a HIPAA compliant cloud storage site
- Be aware that most popular email services (ex. Gmail, Hotmail, Yahoo) do not utilize encrypted email
- When we send you an email, or you sent us an email, the information this is sent 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 you, someone may be able to access your email account and read it.
- Email is a very popular and convenient way to communicate for a lot of people, so in their latest modification to the HIPAA act the federal government provided guidance on email and HIPAA
- The information is available in a pdf (page 5634) on the U.S. Department of Health and Human Services website: https://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013-01073.pdf
- HIPAA guidelines state that if a client has been made aware of the risks of unencrypted email, and that same client provides consent to receive health information via email, then a health entity may send that client personal medical information via unencrypted email.

OPTION 1 – ALLOW UNENCRYPTED EMAIL

I understand the risks of unencrypted email and do hereby give permission to Tracey Long, RDN, and Big Picture Health LLC to send me personal health information via unencrypted email to the email address below.

_____

Client Name

_____ _____ _____

Signature Date Email address

☐ I understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the above Terms.

(legal guardian may sign for a child under age 18)

OPTION 2 – DO NOT ALLOW UNENCRYPTED EMAIL

I do not wish to receive personal health information via email.

_____

Client Name

_____ _____

Signature Date