Miami Counseling & Resource Center

111 Majorca Avenue, Suite B Coral Gables, FL 33134
Phone (305) 448-4835 Fax (305)448-0687

NUTRITION THERAPY

TREATMENT INFORMATION

"Welcome to our office"

We are pleased to offer you and your family nutrition therapy at the **Miami Counseling and Resource Center.**

Amy Jaffe, M.S., R.D., L.D., is a registered and licensed dietitian/nutritionist with many years of experience and formal training in the treatment of eating disorders and weight related issues.

Enclosed you will find some forms that will aid us in assisting you more effectively.

Appointment cancellations: If you cannot attend a scheduled appointment, kindly notify us as soon as possible. Please be aware that you will be charged for any appointment that is not cancelled **twenty-four (24) hours** in advance.

Amy Jaffe can be reached through her direct voicemail number:
(305) 448-8325 ext. 118

Payment for service: Patients are responsible for the full charge at the time of their appointment. Cash, checks or credit card payments are accepted. Please make checks payable to Miami Counseling & Resource Center/MCRC. There is a $20.00 service charge for any check returned from the bank.

Insurance reimbursement: As mentioned, payment for service is expected at the time of your appointment, however, every effort will be taken to assist you in reimbursement of your payment if nutrition therapy is a covered benefit under your insurance plan. Please discuss this further with the nutrition therapist as needed.

Length of session: The initial nutrition therapy session is 90 minutes in duration. Follow-up sessions are 30 minutes in duration. The fee will be assessed on a prorated basis should the session exceed the scheduled duration of the appointment.

Release of information: Confidentiality is of primary importance. Consequently we adhere to very strict standards regarding the release of records and/or information related to you and your family for your own protection.

Finally, good communication is essential for successful treatment. Please feel free to share with us any of your concerns.

INFORMED CONSENT AND AUTHORIZATION FOR TREATMENT

I hereby consent to nutrition therapy assessment, consultation, and treatment. I have read and agree with the terms stated herein.

_____	_____
Patient	Amy Jaffe R.D., L.D./N
_____	_____
Date	Parent/Guardian

____ Copy given to patient (Initials)

PATIENT INFORMATION

NAME:_____,_____DATE:_____
last first
Name you want to be called:_____

ADDRESS:_____APT:_____

CITY:_____STATE:_____ZIP:_____

HOME PHONE:_____WORK PHONE:_____

CELLULAR #:_____E-MAIL ADDRESS:_____

SS#_____SEX: M:____ F:____AGE:_____ DATE OF BIRTH:_____

MARITAL STATUS: MARRIED:_____SINGLE:_____DIVORCED:_____

SEPARATED: _____WIDOWED:_____LIVING WITH SIGNIFICANT OTHER:_____

REFERRED BY:_____

If Internet: key words_____ search engine?_____

REASON FOR REFERRAL:_____

EMPLOYER / SCHOOL: _____ OCCUPATION:_____

ADDRESS:_____

CITY:_____STATE:_____ZIP:_____

EMERGENCY CONTACT:

NAME:_____RELATION TO YOU: _____

HOME PHONE:_____ WORK PHONE:_____CELL PHONE:_____

PRIMARY CARE PHYSICIAN

NAME:_____PHONE #:_____

THERAPIST

NAME:_____PHONE #:_____

PSYCHIARIST

NAME:_____PHONE #:_____

Our office prefers payment to be made by check or cash. However, in an effort to avoid difficulties with your account, please provide credit card information in the space below.

This information will only be used in processing payment due to one or more of the following: copayment balance, returned bank checks, balance for insurance payments made directly to patients, missed or late cancelled appointments, denial of expected coverage by insurance companies or therapy session payment.

Please rest assured that we will make every effort to discuss your account before using this avenue to bring your balance up to date.

Thank you for your cooperation.

CREDIT CARD:

- ☐ **VISA**
- ☐ **MASTER CARD**
- ☐ **AMERICAN EXPRESS**
- ☐ **DISCOVER**

CARD NUMBER: ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

 # ON BACK OF CARD ☐

EXPIRATION DATE: ☐☐☐☐

STREET ADDRESS: _____
(Where statement is mailed)

ZIP CODE: ☐☐☐☐☐
(Where statement is mailed)

SIGNATURE: _____

PRINT NAME: _____

Miami Counseling & Resource Center
111 Majorca Avenue, Suite B – Coral Gables, Florida 33134
Phone (305) 448-8325 – Fax (305) 448-0687

NUTRITION THERAPY FINANCIAL AGREEMENT

I,_____, agree to be responsible for the following charges at the Miami Counseling & Resource Center is Mine.

Initial session:	$_____(90 minutes)
Follow-up session (s)	$_____(30 minutes)

If it is no longer possible for me to continue with this responsibility, I agree to notify in writing the Miami Counseling & Resource Center immediately.

Because the time has been reserved exclusively for me or for my family member, I understand that a twenty-four (24) hour notice of cancellation is required. In the event that the advance notice is not provided, I understand that I will be charged the full fee for the reserved appointment.

Should it be necessary for the Miami Counseling & Resource Center to obtain the services of a collection agency and/or an attorney to collect an overdue balance, the undersigned agrees to pay all reasonable attorney's fees, collection expenses, and court costs incurred in any such action. Balances that have been outstanding over thirty (30) days will begin accruing interest at a rate of 1.5% per month. Interest will continue to accumulate on a monthly basis and will be added to the balance until the entire bill is paid.

_____ _____
Signature Witness

_____ _____
Date Date

Adress:_____