



CONSENT FOR TREATMENT

I consent to treatment from **Sodexo Operations, LLC** and affiliated entities (“Sodexo”). I grant permission to the dietitians, employees and other persons authorized by Sodexo to render routine medical care that includes, but is not limited to diagnostic procedures and medical consultation, and to carry out all orders deemed advisable by my attending or treating physician.

_____ (Initial) **I give permission for Sodexo to communicate medical conditions as well as treatment plan as needed with my referring physician or any other allied health care professional.**

I understand that no guarantee or assurance has been made as to the results that may be obtained. I understand that some of the dietitians providing care to me may not be employees or agents of Sodexo.

I hereby agree to be responsible to Sodexo and to the dietitians and other health care practitioners providing medical services for any and all charges that are incurred during my admission, consultation and/or treatment and not paid or otherwise satisfied by insurance or other third party benefits.

_____ (Initial) **I understand that if I fail to cancel or reschedule my appointment within 24 hours prior notification, I will be charged in full for the appointment.**

_____ (Initial) **I understand that payment in the form of check, cash, credit card, etc. is required for services rendered. Payment is non-refundable whether applied to packages, merchandise, individual counseling, or any other services provided by Sodexo Operations, LLC or its employees.**

In the event that I fail to pay in full for such charges within ten (10) days of demand by Sodexo, I shall be obligated to pay reasonable and necessary costs, including the reasonable legal fees, and collection expenses, incurred by Sodexo in pursuing its claim for payment. I acknowledge that Sodexo may take all necessary steps to collect the debt which may include the use of outside services, such as, collection agencies, attorneys, etc.

Where insurance benefits are applicable, I certify that the information given by me in applying for payment under Title VIII of the Social Security Act is correct. I assign and request payment of authorized Medicare benefits to Sodexo and to the dietitians providing medical service on my behalf for any services finished to me. I authorized any holder of medical or other information about me to release to Medicare and its agents any information needed to determine the benefits for related services.

DATE: _____ **Signature:** _____

Witness: _____



PAYMENT POLICIES

Payment for services is due the day of service by cash, check or credit card. Package rates are also available.

Fees for nutrition counseling are as follows:

- Initial Client Visit: \$65
- Subsequent Client Visits: \$55 (30 minutes)
- Client Evaluation: \$98 (one hour)
- Transformation Package: \$325 (6 sessions)

My payment for nutrition counseling visits includes dietitian communication with other members of my treatment team and reasonable phone communication with my dietitian and staff at no extra charge. Extensive phone communication or phone calls that replace follow-up care, whether scheduled or unscheduled will be billed at the rate of **\$25.00** per quarter hour.

If insurance coverage is not valid for payment upon payment, **Sodexo Operations, LLC** will provide a coded receipt for services (a "Superbill") that may be submitted to insurance providers for reimbursement. These receipts indicate that any reimbursements should be made to the patient or insurance holder, not to **Sodexo Operations, LLC**. In the event of a mistaken insurance payment **Sodexo Operations, LLC**, the insurance check will be voided and sent back to the insurance company with an explanatory letter, and I will be notified with a copy of this letter and voided check.

Appointments are reservations of the dietitian's time, keeping other patients from reserving that time. Therefore even if I do not attend my scheduled appointment, I will be charged for the time reserved. If notice is given in a timely manner (at least 24 hours in advance of my scheduled appointment or 72 hours in advance for Monday appointments), I will not be charged at all.

Credit Card Authorization

Visa MasterCard Other:_____

Number _____ Expiration Date _____

Last three numbers from back of card _____ Zip Code _____

My signature below signifies that I have read, understand, and agree to abide by the above policies, and grants my permission to **Sodexo Operations, LLC** to charge my credit card for any appointment, which is not paid for any reason the day of service, or for any appointment that is not cancelled in the timely manner described above. In the event a valid credit card number has not been provided, I agree to pay by other form of payment after receipt of invoice.

DATE:_____ Signature:_____



Denver Wellness & Nutrition

p: 303-779-9355
f: 303-779-0956
w: denverwellnessandnutrition.com
6767 South Spruce Street, Suite 125
Englewood, CO 80112

Patient's Name: _____ Today's Date: _____

Complete Address: _____

Date of Birth: _____ SSN: _____ Email Address: _____

Home Phone: _____ Work/Cell: _____

Referring Physician: _____ MD Telephone: _____ MD Fax: _____

Medical Diagnosis: _____

Past Medical History: _____

Medications: _____

Do You Take Any Supplements? If so, please list: _____

Lab Data: _____

Do You Have an Exercise Regimen? If so, please describe: _____

Height: _____ Weight: _____ Weight Goal: _____

Recent Weight Change/ Weight History: _____

Food Allergies/Intolerances: _____

Do you drink alcohol? If so, how much? _____ Smoking: _____

Who shops? _____ Who cooks? _____

Frequency of Eating Out: _____ Where?: _____

Prior Nutrition Counseling: _____

Reason for Visit/Specific Questions: _____

Diet History

To the best of your knowledge, please provide a detailed list of items consumed yesterday and an approximate amount (Example: Breakfast: 2 eggs, 2 slices wheat toast and 8 oz of juice):

Breakfast:

Snack:

Lunch:

Snack:

Dinner:

Snack: