Stacie Haaga, RD, CLT
Nutrition and Wellness Counseling

NOTICE OF PRIVACY PRACTICES

In any situation, I will ask for your written authorization before using or disclosing any of your protected health information. If you sign an authorization to use or disclose information, you can later revoke that authorization to stop further uses and disclosures.

Privacy practices may change at any time and the new terms shall apply to all PHI about you. You will be notified if any material changes are made.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

OF STACIE HAAGA, RD, CLT

I acknowledge receiving a copy of the Notice of Privacy Practices of Stacie Haaga, RD, CLT on _____(insert date).

Printed name of patient _____

Printed name of authorized representative (if applicable) _____

Signature or initials of patient or authorized representative _____

Stacie Haaga, RD, CLT
Nutrition and Wellness Counseling
(P) 540.230.6129 | (F) 571.206-3935 | RD@staciehnutrition.com

FINANCIAL POLICY

This is an agreement between Stacie Haaga, RD as creditor and the patient/Debtor named on this form.

Payment Options: You may pay your out-of-pocket costs at the time of service by check, cash or credit card. If you are unable to pay your full out-of-pocket costs at the time of service, you may make payment arrangements with Stacie Haaga. These options include a payment plan not to exceed three months. Automatic payments can be arranged via credit card.

Past Due Accounts: If at any time you have a balance due which is more than 90 days old and have not made appropriate arrangements with Stacie Haaga, your account may be referred to an outside collection agency. If you have established a payment plan and default on the agreed up plan, your account may be referred to an outside collection agency.

Missed Appointment Fee: The second time a patient does not show or cancels with less than 24 hours notice, a missed appointment fee of $35 may be charged.

Once you have signed this agreement, you agree to all of the terms and conditions contained herein and the agreement will be in full force and effect.

Patient Name: _____ Responsible Party:_____

Signature: _____ Date: _____