Carrie Boyd Lutter, RD/LD, LMSW
www.carrielutter.com
750 N. Fielder Rd., Arlington, TX 76012 / 817.275.9601

PERSONAL INFORMATION (Please Print)

Date _____ Social Security _____

Name _____
Last First MI

Address _____
Street City Zip

E-mail Address _____

Telephone (Home) _____ (Work) _____
(Cell) _____

IN THE EVENT OF AN EMERGENCY, I give Carrie Lutter, RD, LD, LMSW permission to contact:
Name _____ Relation _____ Phone _____

Is it OK to leave messages on your answering machine and/or voice mail or with a family member/roommate? Yes ____ No ____

Is it OK to mail correspondence to above address? Yes ____ No ____

Date of Birth _____ Age _____ Gender _____ Race _____

Married ____ Single ____ Divorced ____ Widowed _____ Cohabitation _____

Name of Spouse or Significant Other _____

Date of Birth (Spouse or Significant Other) _____ Age ____

Education: Years or grades completed _____ Degree(s) earned _____

Types of coursework taken: _____

Occupation _____

Employer _____ How long in present job ? _____

Employer (Spouse) _____ How long in present job? _____

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PERSONAL INFORMATION (Please Print)

Primary Care Physician _____ Physician's Phone _____

List any present medical conditions and current medications

_____

Have you had previous therapy/counseling/psychiatric care? Yes ____ No ____

If yes, when and with whom? _____

How were you referred to me?

_____

_____

_____

Patient Information if client is a minor:

Parent/Legal Guardian Name _____

Address _____

Home Phone _____ Work Phone _____

Occupation _____ Education Level _____

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CONSENT FOR TREATMENT AND AUTHORIZATION FORM FOR USE OF PROTECTED HEALTH INFORMATION

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

Parent/Legal Guardian Name: _____
(Applies only if client is under 18)

I hereby consent to participating in psychotherapy or nutrition services with Carrie Lutter, RD, LD, LMSW, and understand that all information I provide is private, confidential, and protected by law as described in the Privacy Practices. When necessary to coordinate my treatment and healthcare, and as described in the Privacy Practices, my protected health information may be obtained from and/or provided to my:

Insurance Company: _____ Primary Care Doctor: _____

Address: _____

Phone: _____ Fax: _____

Other Doctor (Relationship: _____) Name: _____

Address: _____

Phone: _____ Fax: _____

Psychologist or Counselor: _____

Address: _____

Phone: _____ Fax: _____

Carrie Lutter, RD, LD, LMSW is hereby released from legal responsibility or liability for the release of information authorized herein. I understand that I have the right to revoke this authorization in writing at any time by sending notification to Carrie Lutter, RD, LD, LMSW at the address above. I understand that I have the right to (1) inspect or obtain a copy of the protected health information to be provided as permitted under federal and state law, and (2) refuse to sign this authorization. My signature indicates my understanding and acceptance of the above policies.

Client/Parent/Legal Guardian Signature: _____ Date: _____

(This section below applies only to patients who are less than 18 years of age.)
I hereby give permission for my child to receive counseling with Carrie Lutter, RD, LD, LMSW without a parent or guardian present, and I release Carrie Lutter, RD, LD, LMSW from any and all liability for any incidents or injuries that may occur during my child's appointment or when my child is traveling to or from his/her appointment. I understand that information discussed during counseling sessions will not be released to parents against a minor child's will, except for information of a life threatening nature. In all cases, a minor child will be encouraged to share appropriate information with a parent.

Parent/Legal Guardian Signature: _____ Date: _____

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CLIENT FEE AGREEMENT

1. A sliding scale will be used for psychotherapy services, with fees ranging from $20.00 to $50.00 per 50 minute session. Standard fees for nutrition services are $100.00 per 50 minute session and $50.00 per 25 minute session. Body composition and metabolic measurements are $75.00.

2. **Psychotherapy services only:** Payment will be made to Carrie Lutter, RD, LD, LMSW by check, cash, credit, or debit card. Payment for all other services will be made to Carrie Lutter by check, cash, credit, or debit card.

3. Payment plans are available if prior arrangements have been made.

4. There will be a processing fee of $25 for returned checks.

5. Cancellations must be received **at least 24 hours** before your scheduled appointment; otherwise **you will be charged the full appointment fee for that missed appointment.** You are responsible for calling to cancel or reschedule your appointment. The reason for this is that when you make an appointment you are reserving a time. As your therapist/dietitian, I have agreed not to utilize that time slot for any other purpose. If you fail to keep your appointment and fail to give adequate notice, I am unable to schedule another use for that part of my work day.

6. My method(s) of payment will be (please check all that apply):

____ Cash ____ Personal Check ____ Debit Card ____ Credit Card

Debit/Credit Card Authorization ☐ Visa ☐ MasterCard

Name as it appears on card:_____ Date of Birth:_____/_____/_____

Card Number:_____ Expiration Date:_____/_____

Last 3 or 4 numbers from front/back of card _____

I have read and understand the client fee agreement. I am responsible for all outstanding balances incurred by me. I also understand that payment is due at the time of the session unless prior arrangements have been made. My signature below signifies that I have read, understand, and agree to abide by the above policies, and grants my permission to charge my debit/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.

Client Signature _____ Date _____

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NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

LEGAL DUTY AND COMMITMENT TO YOUR PRIVACY

To my clients: My practice is dedicated to maintaining the privacy of your protected health information, known as PHI. Because of the Health Care Information Portability and Accountability Act of 1996, known as HIPAA, I am required by law to provide you with this Notice of Privacy Practices and of our legal duties regarding your PHI.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

I provide each client (and client's parent, for those under 18 years of age) with an authorization form to allow me to provide PHI to your other health professionals and your insurance company when it is necessary to coordinate your treatment, to obtain payment on your behalf or on behalf of one of your other health care providers, or for health care operations (the administration of this practice and our patient services).

I am also required or permitted to provide your PHI without additional authorization in the following situations: to you or your personal representatives upon request; when required by the Secretary of the Department of Health and Human Services and for public health activities; to our business associates; for certain incidental uses or disclosures; for face-to-face communications that I make with you regarding products or services; to provide gifts of nominal value to you or your family; to correctional institutions if you are an inmate; to help prevent or control communicable diseases; to your employer in limited circumstances, typically related to workplace injuries or medical surveillance; for reporting abuse, neglect or domestic violence; for health oversight activities authorized by law (such as civil or criminal investigations, audits, licensure and disciplinary proceedings, etc.); for judicial and administrative proceedings (such as in response to court orders or discovery requests); for law enforcement; to funeral directors, coroners and medical examiners; for purposes of organ, eye or tissue donation; to avoid a serious threat of harm to health and safety; for specialized governmental functions (e.g., military operations; national security); for auditing purposes; for certain research studies; for workers' compensation purposes; for emergencies or disaster relief; to persons involved in your care or payment related to your care; for notification purposes with respect to your care, condition, location or death.

I may also contact you about appointment reminders, treatment alternatives or with educational information regarding your health condition. In any other situation, I will ask for your written authorization before using or disclosing any of your PHI. If you sign an authorization to use or disclose information, you can later revoke that authorization to stop further uses and disclosures.

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NOTICE OF PRIVACY PRACTICES

YOUR INDIVIDUAL RIGHTS

Communications: You can request that my practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that I contact you at home rather than at work. I will accommodate reasonable requests.
Restrictions: You can request a restriction in my use or disclosure of your health information for treatment, payment, or health care operations. Additionally, you have the right to request that I restrict disclosure of your health information to only certain individuals involved in your care or the payment of your care. I am not required to agree with your request. However, if I do agree, I am bound by our agreement except when specifically authorized by you, otherwise required by law, in emergencies, or when the information is necessary to treat you.
Inspect and Copy: You have the right to inspect or obtain a copy of the health information that may be used to make decisions about you for as long as the PHI is maintained in the record. I may charge a fee for costs related to your request. I may, under certain circumstances, deny your request but if I do, you can obtain a review of that denial by another licensed health care professional that I designate.
Amend: You have the right to request an amendment by me of your health information if you believe it is incorrect or incomplete, as long as this information is kept by and for my practice. Your request must be made in writing and submitted to me at the address above. You must provide a reason that supports your request. I have the right to deny such a request under certain circumstances.
Complaints: If you believe your privacy rights have been violated, you may file a complaint with my practice or with the Secretary of the Department of Health and Human Services. To file a complaint with my practice, contact me at the address above. All complaints must be in writing. You will not be penalized or retaliated against for filing a complaint.
Other Authorizations and Accounting: My practice will obtain your written authorization for uses and disclosures not identified by this notice or permitted by applicable law. You also have the right to receive an "accounting", which lists certain instances when I have disclosed PHI about you for reasons other than treatment, payment or healthcare operations. The request can cover a time period no longer than six years from the date of disclosure. Your first request in a 12-month period is free. After that, I may charge for costs related to additional requests.

CHANGES IN NOTICE OF PRIVACY PRACTICES

I may change the privacy practices at any time and the new terms shall apply to all PHI about you that I have at the time of the change and to all PHI about you that I maintain in the future. If any material changes are made, I will change the Notice of Privacy Practices and post it in the waiting area of my office. The changes will not take effect until they are reflected in a revised Notice of Privacy Practices. You may request a copy of the Notices of Privacy Practices at any time.

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ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES FOR CARRIE LUTTER, RD, LD, LMSW

Please sign and return this page.
You may keep the Notice of Privacy Practices for your records.

Client Name (printed) _____

Date of Birth _____/_____/_____

Parent/Guardian Name (if client is under 18) _____

I acknowledge receiving a copy of the Notice of Carrie Lutter's Privacy Practices on _____/_____/_____.

_____
Patient Signature (or Parent/Guardian signature if client is under 18)

For Office use only.
If written acknowledgment was not obtained, please explain below: