Personal Medical History

Patient's Name: _____
Date of Birth:____/____/_____ Sex:_____ Age:_____
Address:_____City_____Zip_____
Ethnicity:_____
Home Phone:_____ Work Phone:_____
Cellular:_____ Email Address:_____
Referred By:_____

Health Insurance
Insurance Carrier Name:
Subscriber Number:
Group Number if applicable:
Subscriber Name and birthdate:

Doctor(s) Name	**Phone Number**	**Address**
Medical Doctor:		
Therapist:		

Current Medications

Food Allergies

Previous Illnesses	**Date**	**Previous Surgeries**	**Date**

Emergency Contact:		
Name:	**Relationship to Patient:**	**Phone number:**

Daryl Ann Smith RD LD CEDRD

Daryl Ann Smith RD LD CEDRD
315 Uluniu St., Suite 207
Kailua, HI 96734

CONSENT TO OBTAIN AND/OR RELEASE INFORMATION

Patient _____ Birthdate___/___/_____

Former Name (if any) _____

I authorize the exchange of information as noted below between Daryl Ann Smith and:

Name: _____

Address:_____City_____State_____Zip_____

For the purpose of:
_____Coordination of services
_____Contact with referral source
_____Continuity of care
_____Other:_____
Daryl Ann Smith will release:
_____Verbal and/or written communication
_____Full Nutrition Assessment
_____Follow-up documentation
Daryl Ann Smith will obtain:
_____Verbal and/or written communication
_____Medical, excludes protected
_____Complete Health Record
_____Summaries only
_____Lab Reports
_____Consultation reports
_____Other:_____
Protected:
_____Mental Health Treatment Summaries only
_____Psychosocial History and Assessment
_____Psychiatric and/or educational evaluation

I hereby release Daryl Ann Smith from all liability and claims of any nature whatsoever pertaining to disclosure information or any professional opinions, findings or recommendations as contained in treatment records. Records released under this consent are not to be considered part of the records of the facility receiving the information.

Patient/Legally Responsible Party_____Date_____

Relationship to Patient_____Date_____

Witness_____Date_____

COPY IS AS VALID AS ORIGINAL

Daryl Ann Smith, RD LD CEDRD
315 Uluniu St, Suite 207
Kailua, HI 96734

NO-SHOW AND LATE CANCELLATION POLICY

Appointment slots reserved for you are not able to be utilized by the Nutrition Therapist if you fail to report for your appointment. For this reason, Daryl Ann Smith may charge for missed or for appointments cancelled with less than 24 hour notice. .

Charges are as follows:

$60.00 for appointments 30 minutes or less
$120.00 for all other appointments including initial appointments

If you would like reminder calls about your upcoming appointment, please request that they be provided and all efforts will be made to remind you of your appointments. Prepaid appointments are non-refundable. Credit cards used to hold appointments will be charged for no-shows. In cases of missed appointments due to emergency, you may appeal the charge in writing and your appeal will be reviewed.

Signature Date

WRITTEN ACKNOWLEDGEMENT OF PRIVACY POLICY

I have received and read Daryl Ann Smith's HIPAA Privacy Notice. (Available at https://darylannsmith.com/privacy/)

Signature Date

Telehealth Consent Form

Daryl Ann Smith RDN LD CEDRD

1. I hereby authorize Daryl Ann Smith to use the telehealth practice platform for telecommunication for evaluating, testing and diagnosing any medical condition.

2. I understand that technical difficulties may occur before or during the telehealth sessions and my appointment cannot be started or ended as intended.

3. I accept that the professionals can contact interactive sessions with video call; however, I am informed that the sessions can be conducted via regular voice communication if the technical requirements such as internet speed cannot be met.

4. I understand that my current insurance may not cover the additional fees of the telehealth practices and I may be responsible for any fee that my insurance company does not cover.

5. I agree that my medical records on telehealth can be kept for further evaluation, analysis and documentation, and in all of these, my information will be kept private.

Name: _____ Date: _____

Signature: _____