



7900 N. Milwaukee Ave. Suite 18,
Niles, IL 60714
847-581-1160

Welcome to the Office of DMA Nutrition Inc.

Mission Statement:

DMA Nutrition Inc. is the visible expression of a commitment made by the dietitians and by all who serve with them to provide quality health care to those needing this service. This commitment is characterized by a reverence for life based on our belief in human dignity. We nourish among us a spirit for health and a spirit of excellence.

Payment and Insurance Liability Notice:

In many cases, your insurance company will limit payment or may not cover a service due to limitations of your policy. If your insurance does not pay for a service due to a policy limitation, you are financially responsible for the payment of that service.

Missed/Late Appointments:

Please help us to serve you better by **calling our office** at least 24 hours in advance if you are not able to keep your scheduled appointment. **Missed appointments without prior notification will result in a \$45.00 charge.** If you know you will be late for your appointment, please call and let us know as soon as possible. Being on time for your visits will ensure that you receive all the precious time needed to achieve your goals!

Visitors:

You are encouraged to bring to one or two persons (at no charge) to your visit who have direct impact on your nutritional intake (those who prepare or purchase your meals, who dine with you, etc.). We respectfully ask that you do not bring young children and/or pets, unless first discussed with our staff.

Authorization for Release of Medical Information:

I _____ (name) hereby give my consent to **DMA Nutrition Inc.** to release and share information regarding my nutritional status to my primary care physician. I understand that I have the right to copy and inspect the information which is to be released. I further understand that the records contain information regarding the patient's medical condition and treatment and possibly could include information pertaining to drug and/or alcohol usage, mental health status, and/or HIV status. I understand that my refusal to consent to the release of this information will prevent the disclosure of such information. (The record may be subject to subpoena or court order if it does not contain alcohol, drug, or mental health information.) It is further understood that I have the right to revoke this authorization in writing at any time, and in any case it expires when the processing of this request is completed.

Consent for Nutritional Program:

Our nutritional services are not meant to replace the advice of your physician, and/or your medication regimen. We do not diagnose, prescribe or medically treat any condition, disease or disorder, nor do we interfere with the medical advice given by your doctor. We do not claim that any recommended nutritional supplements such as vitamins, minerals, herbs or proteins will cure any condition. We do access your nutritional health in order to make nutritional recommendations, which are based on current, reliable and sound authority from respected researchers in nutrition. We communicate these recommendations to your referring physician. I understand that if I am in pain or discomfort, I should immediately seek **MEDICAL TREATMENT**. I have read this **Consent** and certify that I understand its contents. I _____ (name) hereby give my consent to **DMA Nutrition Inc.** to provide me with medical nutrition therapy, diabetes education, weight management counseling and/or other nutrition-related services.

Date: _____ OR _____
Patient Name (Please Print) Patient Representative (Please Print)

_____ OR _____
Patient Signature Patient Representative Signature
