Informed Consent and Understanding of Financial Responsibility

Before we begin working together, we would like you to fully understand several important aspects of how treatment works at The Eating Disorder Trap, Inc. Robyn L. Goldberg, RDN, CEDRD-S. Please read this and ask for clarification if necessary before you sign.

Professional Orientation and Treatment Services

The foundation of the care that is provided is as follows The Eating Disorder Trap, Inc. Robyn L. Goldberg, RDN, CEDRD-S focuses on the nutritional care for those struggling with feeding and eating disorders as well as body image issues, and medical issues through nutrition therapy. The care encompasses a Health at Every Size (HAES) approach which recognizes and honors body diversity, lived experiences, and respects differences in gender, ethnicity, race and age.

Standard interventions include:

1. Self-monitoring, including food diaries and journaling.
2. Developing a nutritional plan and adjusting that plan based on your specific needs
3. Skills, including but not limited to learning how to become an intuitive eater.

The hours during which treatment services are available vary by the provider's schedule. Appointments are required for treatment sessions.

Risks

It is possible that discussing your concerns and completing assignments will generate discomfort. If you have any concerns, please raise these with us. At any time you may ask us to explain the approach and techniques, and we will be glad to explain them.

Professional Information

Robyn L. Goldberg, RDN, CEDRD-S, Registered Dietitian Nutritionist & Certified Eating Disorder Registered Dietitian Supervisor through the International Association of Eating Disorder Professionals (iaedp)

You can reach us as follows: Robyn L. Goldberg, RDN CEDRD-S rlgrd@askaboutfood.com; 310-273-0413

Back-up for life-threatening mental health emergencies please dial 911

Confidentiality

All identifying information about your treatment and treatment records are kept confidential. There are some exceptions to confidentiality according to state laws:

1. We are required to inform the appropriate authorities if we have information about abuse of a child, elderly person, or dependent (e.g., disabled) adult.
2. If you seriously threaten to harm someone else, we have the legal duty to try to warn that person and the police.
3. If you seriously threaten to harm yourself, we may need to contact the police and/or a family member.
4. If your records are subpoenaed by an attorney, they will not be released without your written consent. However, they must be released if a court order signed by a judge orders us to do so.
5. If you are using insurance, we may be asked by the insurance company for ongoing treatment reports. These would include a diagnosis, a summary of treatment to date, and plans for future sessions.

Reference the Notice of Privacy Practices for more complete information regarding privacy and confidentiality practices.

Fees, Methods of Payment, and Financial Responsibility

By signing this agreement, you accept financial responsibility for services. Payment must be made at the time of service, by cash or check written out to The Eating Disorder Trap, Inc. or credit card. Credit card payments are processed through Stripe credit card processing, which retains your credit card information in the secure electronic billing system of The Eating Disorder Trap, Inc. Your card will be charged if needed for late cancel and no-show fees. If you cancel (or reschedule) your session with less than 24 hours' notice there will be a late cancellation fee of 50% of your individual session rate, and you will be billed and charged accordingly. Notification can be sent after hours. If you no-show for your session without sending notification ahead of time or if you send notification after the scheduled start time of the session to cancel or reschedule, you will owe your entire hourly fee and be billed and charged accordingly. Late cancellation and no-show fees apply regardless of form of payment (cash, check, or credit card) and are not negotiable, regardless of the reason for not keeping

By initialing and dating, you are indicating that you have read and agree to the information detailed on this page.

Client Initials: ____ Date: _____ Parent Initials: ____ Date: _____ Parent Initials: ____ Date: _____

the scheduled appointment. Non-payment of fees may result in service discontinuation. I am available to answer any questions that you may have in between sessions during the week for a few minutes. You may leave me a message and I will return your call as soon as possible. You are welcome to leave me a voicemail or an email stating thoughts or concerns. I will read it but print it out and save it for discussion at our next appointment. You will be billed accordingly if you need to speak to me for longer than a few minutes, if you find you are needing more support please consider setting up an additional appointment.

Right to Withdraw Consent for Treatment and Discontinuation of Services

Discontinuation of services may occur under the following circumstances:

1. You have the right to withdraw consent for treatment and may choose to end participation at any time. Before doing so we would simply ask to discuss and problem solve as appropriate; a termination session would usually be requested for adequate clinical closure and transition of care, including referrals.
2. We may recommend alternate care if it is our clinical judgement that you need a level of care that is outside our area of expertise or is more intensive than we can provide.
3. In the event of nonpayment, we will talk with you and attempt to arrive at a mutually agreed upon solution. If we cannot mutually agree on a solution, or if nonpayment continues after arriving at that mutually agreed upon solution, services may be discontinued.
4. We have a zero tolerance policy for threats or aggression towards staff or clients. We also have a zero tolerance policy for threatened or actual aggressive destruction of property. These actions will result in immediate service discontinuation.

Acknowledgement and Signature

By signing below, you certify that you have read the above information and have had an opportunity to ask questions to clarify the conditions under which you consent to treatment. You also acknowledge that you have been offered a copy of this agreement and have either received the copy or have declined it.

Name of Client: _____ Date of Birth: _____

Address: _____ Social Security #: _____

Driver's License: _____ Email: _____

Home Phone Number: _____ Work Phone Number: _____

Client Signature (12 years old or older): _____ Date: _____

If a Minor (under 18): Name of Parent/Guardian: _____

Parent Signature: _____ Date: _____

Name of Parent/Guardian: _____

Parent Signature: _____ Date: _____

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Client Initials: ____ Date: _____ Parent Initials: ____ Date: _____ Parent Initials: ____ Date: _____