nutrition in motion

REGISTRATION FORM

DATE: _____/_____/_____

PATIENT INFORMATION:

Patient Name: _____

Address: _____

City: _____ State: _____ Zip_____

E-mail: _____

Telephone: (home) _____ (Work) _____

Cell: _____

Sex: ___M ___F Date of Birth: _____/_____/_____

INSURANCE INFORMATION:

Insurance Co.: _____

ID#/Group#: _____ (Group): _____

Subscriber's Name: _____

Subscriber's DOB: _____/_____/_____

Relationship to Patient: _____

Is patient covered by additional insurance? ___Yes ___No

2nd Insurance Co.: _____

ID#/Group#: _____ (Group): _____

Subscriber's Name: _____

Subscriber's DOB: _____/_____/_____

Relationship to Patient: _____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with _____ (name of insurance company(ies) and assign directly to Nutrition in Motion all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Nutrition in Motion may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determine insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Guardian or Personal Representative:

_____

Please print name of Patient, Guardian or Personal Representative:

_____

Date:_____ Relationship to Patient: _____

nutrition in motion

MEDICAL HISTORY

DATE: _____/_____/_____

PATIENT NAME: _____ PREFERRED NAME: _____

AGE: _____ HEIGHT: _____ WEIGHT: _____

REASON FOR APPOINTMENT/GOAL: _____

MEDICAL HISTORY - Check the following that you have been diagnosed with:

❍ Anemia	❍ Arthritis	❍ Anxiety	❍ Back Pain	❍ CKD stage
❍ Cancer: _____	❍ Chronic Fatigue	❍ Depression	❍ Dermatitis	❍ Diabetes: Type 1 or 2
❍ Diverticulosis	❍ Fatty Liver Disease	❍ Fibromyalgia	❍ Gastroparesis	❍ GERD
❍ GI: constipation/diarrhea	❍ Gout	❍ Heart Disease	❍ Headaches/Migraines	❍ High Blood Pressure
❍ High Cholesterol	❍ Hypothyroidism	❍ Kidney Stones	❍ Leg/Foot Ulcers	❍ Osteoporosis
❍ PCOS	❍ Sleep Apnea	❍ Thyroid Disease	Any others not listed: _____	

Food Allergies: _____ Food Intolerances: _____

Do you have a history of any eating disorder? (ie. Anorexia/Bulimia or Binge Eating) _____

Do you follow any alternative protein diets? ❍ Pescatarian ❍ Vegetarian ❍ Vegan

Please list any medications you are currently taking: _____

_____

_____

Please list any vitamins, herbs, or supplements you are currently taking: _____

_____

From past 5 – 10 years: Lowest Weight _____ Highest Weight _____ Goal Weight _____

Are you currently pregnant? ❍ Yes ❍ No Due date: _____ Pre-Pregnancy weight _____

Are you currently exercising? ❍ Yes ❍ No If yes, how often, how long, and what types? _____

_____

Are you an emotional eater? ❍ Yes ❍ No If so, what triggers you to eat? _____

Have you ever been seen by a dietitian before? ❍ Yes ❍ No If so, how long ago? _____

Have you had weight loss surgery? ❍ Yes ❍ No _____ Year:_____ Type: _____

Have you tried any diets in the past? ❍ Yes ❍ No _____ What types: _____

What is your current occupation? _____ How many hours/week do you work? _____

Do you smoke? ❍ Yes ❍ No How much and how often? _____

Do you drink? ❍ Yes ❍ No How much and how often? _____

FAMILY MEDICAL HISTORY - Check those that apply, circle the direct family member:

❍ High Blood Pressure: Mother/Father	❍ High Cholesterol: Mother/Father
❍ Diabetes: Mother/Father	❍ Hyper/Hypothyroidism: Mother/Father
❍ Anemia: Mother/Father	❍ Obesity: Mother/Father
❍ Heart Disease: Mother/Father	❍ Osteoporosis: Mother/Father
❍ Nutrient Deficiency: Mother/Father	❍ Cancer: Mother/Father - Cancer type: _____

Any others not listed: _____

nutrition in motion

A CLEAR PATH TO A HEALTHY LIFESTYLE

1505 Medical Center Drive
Wilmington, North Carolina 28401
910.239.3562

The following information is provided to avoid any misunderstandings of Nutrition in Motions policies and payment for professional services rendered.

- Nutrition in Motion has a 24 hour cancellation policy. No shows or cancellations within 24 hours of your appointment time will be charged a $75.00 fee.
- As a courtesy to our patients that show up on time for their appointment, all patients that are late to their appointment may have to forfeit any time missed and may be responsible for the full amount of their appointment.
- Nutrition in Motion has a $35.00 return check fee on all returned checks. Note: Criminal procedures may take place if patient has a history of this matter, please make sure you have sufficient funds before signing check.
- Bills that are not paid within 90 days will be sent to collections.
- It is the responsibility of the patient to read all instructions on all supplements, read all ingredients in all supplements and contact their health care provider in reference to any questions regarding medication or health concerns prior to taking any supplements. It is also the responsibility of the patient to confirm any and all exercise and nutrition recommendations with their health care provider.
- Nutrition in Motion may report information about patients in the aggregate but does not release the patient's name without patient consent.
- I agree to have my health information shared with the referring physician
- Nutrition in Motion reserves the right to charge a reasonable fee for any extra copies and fax services.
- I also give permission for Nutrition in Motion to leave a voice mail if needed with the phone numbers I listed on my patient registration form.
- I understand Nutrition in Motion Notice for Privacy Practice. I understand that a copy is available at check in for patients to review. I understand that I may request a copy of the Notice of Privacy Practice at any time.
- I agree to be seen as a patient with Nutrition in Motion and agree to the above policies for Nutrition in Motion to the best of my knowledge, the information I share with Nutrition in Motion and its employees is correct.
- At the time of class/one-on-one visit, if there is a taste test offered or samples available, I participate per my own wishes and do not hold Nutrition in Motion liable for anything.

I HAVE READ AND I COMPLETELY UNDERSTAND ALL OF NUTRITION IN MOTION POLICIES AS STATED ABOVE.

Signature _____ Date _____/_____/_____

HIPPA Privacy Rule of Patient Authorization Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I, _____ (Patient's Name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my health care;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I have been provided with a copy of the ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this facility's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review this facility's Notice of Information practices prior to signing this consent;
- that this facility reserves the right to change the notice and practices and that prior to implementation will mail a copy of any notice to the address I've provided, if requested;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my Protected Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that this facility is not required by law to agree to the restrictions requested;
- I may revoke this consent in writing at any time, except to the extent that this facility has already taken action in reliance thereon.

Signature of Patient or Legal Representative Witness: _____

Printed Name of Patient or Legal Representative Witness: _____

Date: _____

HIPAA Privacy Rule Receipt of Notice of Privacy Practices Written Acknowledgement Form

Acknowledgement of Receipt of Information Practices Notice (§164.520(a))

I, _____ (Patient's Name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I acknowledge that I have been provided with and understand this facility's **Notice of Privacy Practices** provides a complete description of the uses and disclosures of my health information. I understand that:

- I have the right to review this facility's ***Notice of Privacy Practices*** prior to signing this acknowledgment;
- this facility reserves the right to change their ***Notice of Privacy Practices*** and prior to implementation of this will mail a copy of any revised notice to the address I've provided, if requested.

Signature of Individual or Legal Representative Witness: _____

Printed Name of Individual or Legal Representative Witness: _____

Date: _____

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our ***Notice of Privacy Practices***, but it could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barrier prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify)

  _____

  _____

Privacy Official: _____

Date: _____