

NUTRITION ASSESSMENT

DOB: _____

Date of Service: _____

Reason for today's visit:

1. Have you ever worked with a dietitian/nutritionist? YES NO If yes, who:

2. List any medications that you are currently taking:

3. List any herbal and/or vitamin/mineral supplements you are currently taking:

4. Please estimate your current activity level:

5. Any symptoms of: Nausea Vomiting Diarrhea Constipation Gas

6. How would you describe your appetite? _____

7. Height _____ Weight _____ Usual Body Weight _____

Weight History: _____

8. Medical History (circle all / any that apply):

Diabetes	Hypertension	High Cholesterol	Heart Disease
Sleep Apnea	Obesity	Breathing Problems	Reflux
Osteoporosis	Stomach Problem	Thyroid Disease	Arthritis
Depression	Stroke	Headaches	Eye problems

Autoimmune

PCOS

Infertility

Cancer (if yes, what kind)

Other: (if you have a condition not listed above, please list it here)

9. Family Medical History: (please list any medical problems your immediate family suffers/ed from)

10. Do you smoke cigarettes? _____ If yes, for how long _____ How much _____

11. Do you drink alcohol? Daily Occasionally Never

12. Are you currently employed: Yes No

Occupation: _____

13. Do you have any allergies to medication? Yes No

If yes, which _____

14. Do you have any allergies to food? Yes No

If yes, which _____

15. Other allergies: _____

16. Energy: (0 lowest/10 highest) _____ Stress: (0 lowest/10 highest) _____

17. Is there any other medical information concerning you that we should be aware of?

18. List any goals you hope to achieve as a result of nutrition counseling:

19. Please list anything else that you would like us to know:

PATIENT REGISTRATION

Patient Information

Name _____ Social Security # _____
Date of Birth _____ Age _____ Sex: Male Female
Address _____
City _____ State _____ Zip _____
Phone _____ (h) _____ (w) _____ (c)
Fax _____ Email _____
Primary Care Physician _____
Marital Status (check one): single married divorced widowed

Insurance Information

Insurance Provider _____ Plan Name _____
Insurance ID# _____
If the insurance is in the name of someone other than yourself, please complete the following:
Name of Insured _____ Date of Birth _____
Relationship to Patient _____
Address if different than above _____

Employer Information

Employer Name _____
Address _____
City _____ State _____ Zip _____ Phone _____

Emergency Contact Information

Name _____ Relationship to you _____
Phone _____ (h) _____ (w) _____ (c)

Referral

Referred by / How did you hear about our office? _____



PRIVACY CONSENT

By signing below you authorize Nutrition Sense to release medical records pertaining to your treatment to any entity that is responsible for payment of the charges. You also authorize payment of benefits directly to Nutrition Sense.

You have the right to revoke this consent in writing and the revocation will be effective to the extent Nutrition Sense has acted in reliance on your consent.

Signature of Patient _____ Date _____

Signature of Guardian _____ Relationship to Patient _____
(if different from patient)

ACKNOWLEDGMENT OF ACCEPTANCE OF NOTICE OF PRIVACY PRACTICES

Printed Name _____ Date of Birth _____

I hereby acknowledge that Nutrition Sense has provided me with a copy of its Notice of Privacy Practices. I also understand that I am entitled to receive updates upon request if Nutrition Sense amends or changes its Notice of Privacy Practices in a material way. I understand that if I have questions or complaints I may contact:

Nutrition Sense
206.898.9369
shana@nutrition-sense.com

Signature _____

Date

Relationship to the Patient _____

FINANCIAL POLICY

Please understand that the payment of your bill is considered part of your treatment. The following statement explains our financial policy. Please read the policy, sign and return it to us prior to your treatment.

I, _____, understand I am responsible for payment of any charges and agree to pay Nutrition Sense, LLC the regular charges for all nutrition related services rendered to me. I agree to pay those charges that are not covered by or paid by my insurance provider as soon as I receive the bill. If I do not pay my bill, I agree to pay Nutrition Sense, LLC any collection costs it may incur.

If your insurance provider does not cover nutrition visits, payment is due at the time of service. We accept cash, credit and checks.

Returned Checks

For checks returned to us as unpaid by your bank, you will be charged a \$35 fee. Any legal fee that Nutrition Sense, LLC incurs to secure past due balances will be added to your account.

Missed Appointments

Please provide at least 24 hours notice of cancellation as a courtesy. Our policy is to charge \$50 for missed appointments without appropriate notice. Please help us to serve you better by keeping scheduled appointments.

I understand that I am financially responsible for the charges that I incur during my treatment under the care of Nutrition Sense LLC. This includes all nutrition therapies, supplements, office visits, laboratory and imaging charges.

I have read and agree to this financial policy.

Signature of Patient _____ Date _____

Name of Guardian _____ Relationship _____

Signature of Guardian _____ Date _____

Notice of Privacy Practices

Nutrition Sense is committed to protecting your personal health information. Protected health information (PHI) includes information that we have created or received regarding your health, your health care, and payment for your health care.

Washington State and federal laws require us to provide a higher level of protection for some types of PHI. Washington State law provides a higher level of protection for health care information and specifically limits the disclosure of certain types of PHI, including records regarding mental health, confirmed sexually transmitted disease, HIV/AIDS, and drug and alcohol treatment. Information about this type of care can only be released in accordance with those stricter laws. Minors may consent to their own treatment for family planning services, sexually transmitted disease testing/treatment, outpatient mental health treatment or outpatient alcohol and drug abuse treatment.

PART 1 – YOUR RIGHTS WITH RESPECT TO YOUR PROTECTED HEALTH INFORMATION

Here is a listing of your rights with respect to your protected health information, along with a description of how you may exercise these rights:

- You have a right to request limits on the way we use or disclose your health information. You must make the request in writing and tell us what information you want to limit and to whom you want the limits to apply. Nutrition Sense is not required to agree to the restriction.
- You have the right to request how we provide confidential communications to you. For example, we may communicate your test results to you by mail or by telephone. You may ask Nutrition Sense to share information with you in a certain way or in a certain place. For example, you may ask us to send information to your work address instead of your home address; you may also request that we call you at work instead of at home. You must make this request in writing to our. You do not have to explain the reason for your request. We are required to follow your request, if it is reasonable.
- In most cases, you have the right to look at or get copies of your records. You must make the request in writing. We may charge you a reasonable fee based on copying and other costs. In certain situations, we may deny your request and will tell you why we are denying it. In some cases, you may have the right to ask for a review of our denial.
- You have a right to request a correction or an update of your records. You may ask Nutrition Sense to amend or add missing information if you think there is a mistake. You must make the request in writing and provide a reason for your request. In certain cases we may deny your request, in writing. You may respond by filing a written statement of disagreement with us and ask that the statement be included in your PHI.
- You have a right to get a list of persons or agencies to which your records were sent. You must make this request in writing. The list will not include the releases of your information made for the purpose of treatment, payment, or health care operations. The list will not include information provided directly to you or your family, or information that was sent with your written authorization.
- You have a right to get a paper copy of the most recent version of this notice, if you request it.

- You have the right to withdraw your permission for us to release your information. If you sign an authorization to use or disclose information, you can revoke that authorization at any time. The revocation must be made in writing. This will not affect information that has already been used or disclosed.

PART 2 – NUTRITION SENSE’S RESPONSIBILITIES UNDER THE LAW

Nutrition Sense is required by law to provide you with our Notice of Privacy Practices. This law is the Health Insurance Portability and Accountability Act of 1996 (HIPAA). Under this law, we must protect the privacy of your “protected health information” or PHI. PHI is information that we have created or received regarding your health or payment for your health care. It includes both your medical records and personal information such as your name, social security number, address, and phone number.

We are required to:

- Keep your protected health information private except as indicated below
- Follow the terms of the Notice currently in effect
- Give you this Notice

We reserve the right to change our practices regarding the protected health information we maintain. If we make changes, we will update our Notice and make it available to you.

PART 3 – HOW WE MAY USE OR DISCLOSE MEDICAL INFORMATION ABOUT YOU

Nutrition Sense uses and discloses PHI in a number of ways connected to your treatment, payment for your care, and health care operations. Your PHI may be transmitted by FAX for the purpose of treatment, payment or operations. You have the right to ask that we do not transmit your information by FAX. Here are some examples of how we may use or disclose your personal health information without your authorization.

To provide treatment; for example:

- We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses or other healthcare professionals involved in your care. For example, your doctor will need to know if you are allergic to any medicines. The doctor may share this information with pharmacists and others caring for you.
- We may also disclose information to other professionals providing your health care. For example, we may need to tell a specialist about your medical conditions if we refer you to a specialist so you may receive the proper care.

To receive payment for services we provide or to obtain insurance authorization for services we recommend; for example:

- If you have health insurance, we request payment from your health insurance plan for the services we provide. For example, we may need to give your health plan information about your visit, your diagnosis, procedures, and supplies used so that we can be compensated for the treatment provider. However, we will not disclose your health information to a third party payer without your authorization except required by law.
- We may also tell your health plan about your recommended treatment to get their prior approval, if that is required under your insurance plan. For example, if you need surgery, we will call your health plan to make sure the surgery is covered and will be paid for by the health plan.

To carry out healthcare operations; for example:

- We may use or disclose your health information in order to manage our programs and activities. For example, we may use your health information to review the quality of services you receive or to provide training to our staff.

- We may use and disclose medical information to contact you by telephone or by mail as a reminder that you have an appointment for treatment or to inform you of test results.

For Research: We may use and disclose medical information about you for research purposes.

For Joint Activities: Your health information may be used and shared by the Providers in furtherance of their joint activities and with other individuals or organizations that engage in joint treatment, payment or healthcare operational activities with the Providers.

As required by Law: We may use and disclose protected health information when required by federal or state law.

For judicial and administrative proceedings: We may disclose protected health information in response to an order of a court or administrative tribunal; in response to a subpoena, discovery request, or other lawful process.

For law enforcement purposes: We may disclose protected health information to a law enforcement official.

For Abuse Reports and Investigations: Nutrition Sense may use and disclose information regarding suspected cases of abuse, neglect, or domestic violence, when the law so requires.

To Medical Examiners/Coroners or Funeral Directors: We may use and disclose protected health information consistent with applicable laws to allow them to carry out their duties.

To Comply with Workers' Compensation Laws: We may disclose protected health information as authorized by laws relating to workers compensation or other programs that provide benefits for work-related injuries or illness without regard to fault.

For organ, eye, or tissue donation purposes: We may disclose protected health care information to organ procurement organizations or entities.

For Specialized Government Functions: We may use and disclose information to agencies administering programs that provide public benefits. For example, Nutrition Sense may disclose information for the determination of Supplemental Security Income (SSI) benefits. We also may provide information to government officials for specifically identified government functions such as national security or military activities; or law enforcement custodial situations, such as correctional institutions.

To Avoid Serious threat to health or safety: Nutrition Sense may use and disclose protected health information when we believe it necessary to avoid a serious threat to the health or safety of a person or the general public.

For Public Health and Safety Purposes as Allowed or Required by Law: We may disclose protected health information to health care oversight agencies for oversight activities authorized by law.

Disaster Relief: We may use and disclose information about you to assist in disaster relief efforts.

OTHER USES AND DISCLOSURES REQUIRE YOUR WRITTEN AUTHORIZATION:

Uses and disclosures not described in this Notice will be made only as allowed by law or with your written authorization. You may revoke your authorization to use or disclose protected health information at any time; the revocation must be in writing. The revocation will not affect uses or disclosures that have already been made.

Office for Civil Rights

U.S. Department of Health and Human Services
200 Independence Avenue, SW, HHH Building, Room 509H
Washington D.C., 20201
Phone: 866-627-7748

TTY: 886-788-4989

Online:

www.hhs.gov/ocr

Adapted from Notice of Privacy practices from Public Health, Metro King County, October 2007