FOOD sense
Nutrition Counseling

Patient Registration Form

Name: _____ Gender: M/F
(Last) (First) (MI)

Birth date: _____/_____/_____ Marital Status: Single / Married / Other: _____

Address: _____

City: _____ State: _____ Zip: _____

Home #: (____)_____ Work: (____)_____ Cell: (____)_____

Email Address*: _____
*We will never sell or otherwise use your email for any other purpose than direct communication regarding your appointments

Would you like to receive our monthly nutrition e-newsletter? Y N

Would you like reminder calls for your appointments? Y N
If yes, would you prefer: Email Phone Text (circle one)

Referring Physician: _____ Phone: (____)_____

Primary Care Provider: _____ Phone: (____)_____

INSURANCE INFORMATION

Primary Insurance: _____ Phone #: (____)_____

Subscriber Id #: _____ Group #: _____

Subscriber Name: _____ Date of Birth: _____/_____/_____

Subscriber Employer: _____ Relationship to you: _____

Secondary Insurance: _____ Phone #: (____)_____

Subscriber Id #: _____ Group #: _____

Subscriber Name: _____ Date of Birth: _____/_____/_____

Subscriber Employer: _____ Relationship to you: _____

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NUTRITION COUNSELING PATIENT AGREEMENT

Thank you for choosing Food/Sense Nutrition. Please read and sign the agreement below. It lays out billing, scheduling and cancellation procedures. If you have any questions please ask for clarification.

- Payment of all fees is expected at time of service or via check, cash or credit card. We will submit claims to your insurance carrier. However, you are responsible for any deductible, co-insurance/co-payment or any claims denied by your insurance carrier. It is highly encouraged to check your benefits prior to your visit.

- I hereby authorize payment of medical benefits directly to Danielle VenHuizen, RD for all services rendered where applicable.

- I will be responsible to pay a $50 late cancel fee for any missed or cancelled appointments not made at least 24 hours in advance and prior to the scheduled appointment time.

- If I default on my account, I understand I will be subject to finance and/or legal fees in addition to the total account balance.

I read and understand this agreement.

Patient Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES
FOOD/SENSE Nutrition

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal program which requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information. As required by "HIPAA," we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for the following purposes: treatment, payment, and health care operations:

- **Treatment** means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- **Payment** means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- **Health Care Operations** include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example of this would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services which may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information which you can exercise by presenting a written request to Danielle VenHuizen at *FOOD/SENSE* Nutrition:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communication of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of October 1, 2009 and we are required to abide by the terms of the Notice of Privacy Practices currently in effect.

We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office.

You have recourse if you feel that your privacy protections have been violated. You have the right to file written complaint with our office, or with the Department of Health and Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint. Please feel free to contact us for more information.

For more information about "HIPAA" or to file a complaint contact:
The U.S. Department of Health and Human Services, Office of Civil Rights, 200 Independence Ave., S.W.
Washington, D.C. 20201 202-619-0257 Toll Free: 1-877-696-6775

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES OF *FOOD/SENSE* NUTRITION

By my signature below, I acknowledge receipt of the Notice of Privacy Practices.

_____ _____

Patient or legally authorized individual signature Date

_____ _____

Printed Name Relationship
(parent, guardian, etc)

If you have the time (this is not required, but helpful), please complete this form to the best of your ability and either bring with you to your consultation or send via email to Danielle@foodsense.net

Name:

Reason for consultation: _____

What do you hope to achieve in your nutrition consultation?

_____

_____

Health and Medical History: Please indicate all that apply with a C (current) or P (past) in box to left

	Food allergies / intolerances		Diabetes
	Eating disorder		GI condition
	Other:		

Please name any medications, vitamins, botanicals, probiotics and any other supplements you use.

_____

Physical Activity:

Type of activities, how often, how long: _____

_____

Sleep:

Duration most nights: □ 8+ hrs □ 6-8 hrs □ <6 hrs Sleep quality most nights: □ Good □ Fair □ Poor

Stress:

On a scale of 1-10, what is your stress level most days (1=minimal, 10=extreme)? _____

Life stressors: □ Work □ Finances □ Health □ School □ Other

Height/Weight:

Height: _____ Current Weight: _____

Goal Weight (if applies): _____

Weight History (highest/lowest as an adult): _____

Food Habits:

Do you follow a specific diet or eating pattern? _____

Do you avoid any particular food or beverages? _____

Do you have a meal plan? □ Yes □ No

Do you grocery shop? □ Yes □ No

Do you cook? □ Yes □ No

What do you think would make the most difference in your overall health?

_____

_____

_____

_____

_____

_____

Please write a brief summary of any other information that you want me to know regarding your health history.

_____

_____

_____

_____

_____