NuWeights
NUTRITION & PERSONAL TRAINING

Patient Registration Form

Patient's Name: _____ (Last), _____ (First), _____ (M.I.) Gender: ☐ Male ☐ Female

Date of Birth: _____ (Month) (Day) (Year) SSN: _____ Marital Status: ☐ Single ☐ Married ☐ Other

Address: _____ (Street #) (Street Name) City: _____ State: _____ Zip:_____

Home #:_____ Cell #:_____Work #: _____ E-mail Address: _____

Patient's Employer: _____ Occupation: _____

Employer's Address: _____ Business Phone: _____

How did you find out our office: ☐ Insurance website ☐ NuWeights website ☐ Referral ☐Your Health Add ☐ Other

_____

Referring Physician: _____

Emergency Contact: _____ Relationship: _____ Phone#:_____

Primary Care Physician: _____ Business phone#: _____

Medical Insurance Information

Do you have a medical Insurance? ☐No ☐Yes. If yes,

Subscriber's Name: _____ (if different from patient) (Last) (First) (M.I.) Date of Birth: _____

Insurance Name: _____ Member's ID# _____Group# _____

Relationship to patient: ☐ Self ☐Spouse ☐Child ☐Other _____

Assignment of Insurance Benefits

I HEREBY AUTHORIZE PAYMENT OF ALL MEDICAL INSURANCE BENEFITS WHICH ARE PAYABLE TO ME UNDER THE TERMS OF MY INSURANCE POLICY TO BE PAID DIRECTLY TO THIS MEDICAL PROFESSIONAL FOR SERVICES RENDERED. I FURTHER AUTHORIZE THE RELEASE OF ANY INFORMATION NEEDED FOR PROCESSING MY INSURANCE CLAIMS. A COPY OF THIS AUTHORIZATION MAY BE USED IN PLACE OF THE ORIGINAL. IF I DO NOT PROVIDE YOUR OFFICE WITH A REFERRAL WHEN REQUIRED, I WILL BE FINANCIALLY RESPONSIBLE FOR PAYMENT.

I UNDERSTAND AND AGREE THAT I AM FINANCIALLY RESPONSIBLE FOR CHARGES NOT PAID BY MY INSURANCE COMPANY.

_____ _____

Print Full Name, Financially Responsible Party Date

_____

Signature, Financially Responsible Party

Revised January 23, 2013

FINANCIAL AGREEMENT

ANY CHANGES MADE TO THIS FORM ARE NULL AND VOID

PLEASE REMEMBER that insurance is considered a method of reimbursing the patient for fees paid to the medical provider and is *not* a substitute for payment. My agreement with the insurance company is ***between my insurance company and I***. I understand it is my responsibility:

- For knowing the terms, regulations, and limitations of my insurance plan.
- For obtaining referrals when they are required by my insurance plan for coverage.
- To pay any deductible, co-insurance or non-covered amount not paid by my insurance plan for care provided to me or my dependent.

NuWeights makes no guarantee of insurance coverage or insurance payments. If my insurance company does not remit payment within 60 days after the claim is submitted, I will be billed for the full balance and payment is due upon receipt. If NuWeights later receives payment from my insurance company, I will be reimbursed for any overpayments (less co-payments, co-insurance, or other allowable charges).

I agree to pay for services rendered to the patient at the time of service or upon receipt of the first statement mailed by NuWeights. I promise to pay my account when due, and if collection procedures are required for unpaid balances, I am responsible for all costs of collections including, but not limited to, collections fees (generally 30-50%), interest at eighteen percent (18%) per annum from the last date of payment, and any court costs.

Returned Checks: I will pay a $35 fee for a returned check in addition to my full balance, with cash or credit card, within 10 days of being notified by NuWeights.

Missed or Cancellation of an Appointment: Missed appointments not canceled or rescheduled 24 hours ahead of time will be charged $35.

Signature: _____ **Date: _____**

Revised January 23, 2013

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PROTECTED MEDICAL INFORMATION ABOUT YOU
MAY BE USED AND DISCLOSED

This notice covers all information in our written and electronic records about your health. NuWeights Nutrition and Personal Training dietitian-nutritionists, personal trainers and staff may use and disclose medical information (Protected Health Information -- PHI) about an individual for medical treatment, payment and health care operations.

NuWeights Nutrition and Personal Training is permitted, or required under specific circumstances, to use or disclose protected health information without the individual's written authorization, including but not limited to: disclosures required by law, disclosures to avert serious threats to health or safety, disclosures with reference to workers compensation, or disclosures to public health authorities (as examples, but not limited to the Food and Drug Administration (FDA), the Centers for Disease Control and Prevention, and the Occupational Safety and Health Administration (OSHA)).

Other uses and disclosures will be made only with the individual's written authorization and the individual may revoke such authorization. (To provide a written authorization of this protected information, please next page).

NuWeights Nutrition and Personal Training's office policy is to contact the individual by phone, SMS, or email to provide appointment reminders; or information about treatment or other health-related benefits and services that may be of interest to the individual or patient. NuWeights Nutrition and Personal Training will routinely contact patients by telephone, SMS, or email at home and/or at work; and, otherwise unless requested, may leave messages on the appropriate answering or messaging service regarding appointments, test results, etc.

Our patients have the following rights regarding their protected health information (PHI):

A. The right to request restrictions on certain uses and disclosures of protected health information; however, NuWeights Nutrition and Personal Training is not required to agree to a requested restriction.
B. The right to receive confidential communications of protected health communication.
C. The right to inspect and copy protected health information.
D. The right to amend protected health information.
E. The right to receive an accounting of disclosures of protected health information.
f. The right to obtain a paper or electronic copy of this Notice.

NuWeights Nutrition and Personal Training is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and privacy practices with respect to protected health information. NuWeights Nutrition and Personal Training is required to abide by the terms of the Notice currently in effect.

NuWeights Nutrition and Personal Training reserves the right to change the terms of this Notice. The new Notice provisions will be effective for all protected health information that it maintains. NuWeights Nutrition and Personal Training will provide individuals with a revised Notice per request.

Revised January 23, 2013

Authorizations:

Please provide the name(s) of person(s), if any, to whom you permit NuWeights Nutrition and Personal Training to disclose personal health information, as necessary, for your continued health care. Please also note if specific health care information cannot be disclosed (i.e. test results, appointment information, etc). Otherwise, we will disclose only what is necessary for your continued health care in accordance to this privacy policy.

Name of physician you would like to receive notes about your nutrition session(s): _____

Name and Relationship of person(s) permitted to receive PHI (circle or specify relationship to patient)
Spouse : _____
Family/Friend name: _____
Family/Friend name: _____

___ (Initial) I acknowledge and understand that NuWeights Nutrition and Personal Training policy is to send copies of test results and/or other medical information to physicians who either ordered the procedure/consult or are in need of this health information to ensure coordinated and effective diagnosis and treatment, i.e. your designated primary care provider or physicians/dentist seen for consult/treatment. NuWeights' Nutrition and Personal Training policy is to only disclose specific information necessary for coordination of your health care or medical treatment.

___ Initial if you will allow interpreter services if necessary for communication with health care providers.

List below providers you do **not** want all or specific health information sent:

DO NOT SEND PHI to the following Providers:
Provider Name: _____ All or Specify: _____
Provider Name: _____ All or Specify: _____
Provider Name: _____ All or Specify: _____
Provider Name: _____ All or Specify: _____

____ (Initial) I acknowledge and understand NuWeights' Nutrition and Personal Training policy is to contact me by various means when necessary for my health care services that may include my home/work/cell phones, fax, SMS, or email. I also understand that private health information may be included in that communication to me.

(optional) I do not want NuWeights Nutrition and Personal Training to use the following methods of communication which may include my private health information. Please list: _____

I hereby acknowledge that I have read the NuWeights' Nutrition and Personal Training Notice of Privacy Practices and received a copy (if requested).

Signature: _____ Date: _____
Printed Name: _____
Patient Name: _____ Patient DOB: _____

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LIABILITY FORM FOR NUTRITION SERVICES

This form is an important legal document. It explains the risks you are assuming in beginning a nutrition program. It is critical that you read and understand it completely. After you have done so, please sign your name and date in the spaces below.

Nutrition and/or Fitness Disclaimer

The nutrition advice given by "NuWeights" is solely based on the information provided by the client/individual. The nutrition information given is meant only for the client / individual completing the nutrition questionnaire form. It is the sole responsibility of the client / individual to provide complete and provide accurate information. Any misinformation, inaccurate or omitted information may affect the nutritional assessment and/or advice. Any misrepresented information is solely the client's / individual's responsibility. "NuWeights" will not be liable. "NuWeights" provides nutrition counseling only and is not licensed to prevent, diagnose, alleviate or treat any medical conditions, disease, physical or mental ailments or pain or infirmities.

Nutrition and/or Fitness Waiver and Covenant Not to Sue

I have volunteered to participate in a nutrition program under the direction of "NuWeights" which will include, but may not be limited to nutrition planning. In consideration of "NuWeights" agreement to assist me, I do here and forever release and discharge and hereby hold harmless "NuWeights", and their respective agents, heirs, assigns, contractors, and employees from any and all claims, demands, damages, rights of action or causes of action, present or future, arising out of or connected with my participation in any nutrition program including any injuries resulting there from. I acknowledge and agree that no warranties or representations have been made to me regarding the results I will achieve from this program. I understand that results are individual and may vary.

Nutrition Assumption of Risk

I recognize that specific foods may create allergic and possible fatal reactions, most specifically, products containing nuts. I have therefore specified any food allergies/ sensitivities I am aware of. I am aware that specific foods may interact with certain medications. I have discussed such food reactions and the side effects of all of my medications with my doctor or pharmacist and do not hold "NuWeights" responsible for food and medication reactions. I also understand the diet plan I receive will not take my medications into consideration. If I am on medications, I am responsible to consult with my doctor before starting a new diet plan. If I am pregnant or lactating, have high cholesterol, high blood pressure, high blood sugar, diabetes, renal disease, gastric by-pass surgery a family history of gout or any other medical condition that requires special dietary restrictions, I must receive permission from my physician before participating in the specific nutrition program designed for my use, or may be advised to seek help from another health professional.

Signature: _____ Date: _____

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NUTRITION QUESTIONNAIRE

Name: _____ Age: _____ Height: _____ Weight: _____

Weight History: _____

Why are you seeking nutritional counseling? _____

Have you previously tried any modified diets to help you reach your goal?

If yes, please specify: _____

Physician Name: _____ Phone #: _____

Medications: _____

Medical Conditions:

_____

_____

Food allergies/intolerances? _____

Is work stressful? **YES** or **NO** Do you smoke? **YES** or **NO**

Do you drink? **YES** or **NO** Caffeine: **YES** or **NO**

X per week you exercise: _____ Type of exercise: _____

How is your energy level throughout the day? HIGH LOW MODERATE

Do you experience: HEADACHES HIGH BLOOD PRESSURE FATIGUE APPETITE LOSS

STOMACH PROBLEMS OTHER: _____

How do you compensate for your stress? _____

Supplements: _____

Special dietary products: _____

Are there any foods you avoid? _____

Who shops for groceries? _____ Who does the cooking? _____

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TYPICAL EATING HABITS:

Breakfast:

Snack:

Lunch:

Snack:

Dinner:

Snack:

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