NuWeights
NUTRITION & PERSONAL TRAINING
1360 Beverly Road, Suite 102
McLean, VA 22101
Phone: (703) 752-4472

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: ☐ website ☐ referral ☐ other _____

Purpose of your visit: _____

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 PHYSICIAN 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.

_____ _____
Patient's Signature Date

_____
Or if patient/ guardian (if patient is a minor)

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Christine Haas & Eileen Zdun
1360 Beverly Rd. Suite 102
McLean, VA 22101
(703)552-2722

Consent for Purposes of Treatment, Payment, and Healthcare Operations

I consent to NuWeight's (hereby referred to as the "Practice") use and disclosure of my Protected Health Information for the purpose of providing treatment to me, for purposes relating to the payment of services rendered to me, and for the Practice's general healthcare operations purposes. Healthcare operations purposes shall include, but not be limited to, quality assessment activities, credentialing, business management and other general operation activities. I understand that the Practice's diagnosis or treatment of me may be conditioned upon my consent as evidenced by my signature on this document.

For purposes of this Consent, "Protected Health Information" means any information, including my demographic information, created or received by the Practice, that relates to my past, present, or future physical or mental health or condition; the provision of health care to me, or the past, present or future payment for the provision of health care services to me; and that either identifies me or from which there is a reasonable basis to believe the information can be used to identify me.

I understand I have the right to request a restriction on the use and disclosure of my Protected Health Information for the purposes of treatment, payment or healthcare operations of the Practice, but the Practice is not required to agree to these restrictions. However, if the Practice agrees to a restriction that I request, the restriction is binding on the Practice.

It is the office's policy to call or email patients as a reminder of their next scheduled appointment or if they have missed an appointment.

I understand I have a right to review the Practice's Notice of Privacy Practices prior to the signing of this document. The Notice of Privacy Practices describes my rights and the Practice's duties regarding the types of uses and disclosures of my Protected Heath Information.

I have the right to revoke this consent, in writing, at any time, except to the extent that Physician or the Practice has acted in reliance on this consent.

Signature: _____ Date: _____

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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 print your name, email address, and date in the spaces below.

Nutrition and/or Fitness Disclaimer

The nutrition advice given by "NuWeights" (which hereafter refers to: Christine H. Haas, M.S., C.N.S., C.P.T., and Eileen Zdun, M.A, R.D., L.D.) 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.

Name _____ E-mail _____ 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? _____

TYPICAL EATING HABITS:

Breakfast:

Snack:

Lunch:

Snack:

Dinner:

Snack: