WASHINGTON NUTRITION GROUP
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Registration Form

Patient's Information

First Name*
Middle Name
Last Name*

Social Security Number
Date of Birth
Gender
Marital Status

Address*
City*
State*
Zip Code*

Home Phone
Cell Phone
Work Phone

E-mail

Employment Information

Patient's Employer
Occupation
Business Phone

Employer's Address
City
State
Zip Code

Emergency Contact

First Name*
Last Name*
Relationship*

Home Number*
Cell Phone
Work Phone

Medical Information

Referring Physician

First Name | Last Name | Phone Number

Primary Care Physician

First Name | Last Name | Phone Number

Medical Insurance Information

Do you have medical insurance?

- ◯ Yes
- ◯ No

Are you the subscriber?

- ◯ Yes
- ◯ No

Relationship to patient

Subscriber's name (if different from patient)

First Name | Middle Name | Last Name

Date of Birth

Insurance Name | Member's ID Number | Group Number

Survey

How did you find out about us?

- ☐ Insurance Website
- ☐ Washington Nutrition Group Website
- ☐ Search Engine
- ☐ Referral
- ☐ Magazine/Newspaper Add
- ☐ Other

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Assignment of Insurance Benefits

I hereby authorize payment of all medical 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.

Check the box*

☐ 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

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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.

Washington Nutrition Group 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 up on receipt. If Washington Nutrition Group 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 Washington Nutrition Group. 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 Washington Nutrition Group.

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

Print full name

Date

Signature

Revised January 23, 2013

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Notice of Private 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. Washington Nutrition Group 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.

Washington Nutrition Group 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 see next page).

Washington Nutrition Group's office policy is to contact the individual by phone, SMS, or e-mail 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.

Washington Nutrition Group will routinely contact patients by telephone, SMS, or e-mail 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, Washington Nutrition Group 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.

Washington Nutrition Group 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.

Washington Nutrition Group is required to abide by the terms of the Notice currently in effect.

Washington Nutrition Group 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. Washington Nutrition Group will provide individuals with a revised Notice per request.

Authorizations:

Please provide the name(s) of person(s), if any, to whom you permit Washington Nutrition Group 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)

First Name

Last Name

Name and relationship of person(s) permitted to receive PHI

Person 1

First Name

Last Name

Relationship

Person 2

First Name

Last Name

Relationship

Person 3

First Name

Last Name

Relationship

Check the boxes

- [ ] I acknowledge and understand that WNG 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. WNG policy is to only disclose specific information necessary for coordination of your health care or medical treatment.
- [ ] Check 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's Name 1

All information or specify

Provider's Name 2

All information or specify

Provider's Name 3

All information or specify

Provider's Name 4

All information or specify

Check the box*

☐ I acknowledge and understand Washington Nutrition Group 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 e-mail. I also understand that private health information may be included in that communication to me.

Optional

☐ I do not want Washington Nutrition Group to use the following methods of communication which may include my private health information.

Please list

Check the box*

☐ I hereby acknowledge that I have read the Washington Nutrition Notice of Privacy Practices and received a copy (if requested).

Print full name

Date

Signature

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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 “Washington Nutrition Group” 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. “Washington Nutrition Group” will not be liable.

“Washington Nutrition Group” 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 “Washington Nutrition Group” which will include, but may not be limited to nutrition planning. In consideration of “Washington Nutrition Group” agreement to assist me, I do here and forever release and discharge and hereby hold harmless “Washington Nutrition Group”, 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 “Washington Nutrition Group” 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.

Print full name*

Date*

Signature

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Credit Card Authorization

We require your credit card authorization to be on file before we can process your request for service. For your convenience, we will use this authorization to charge your credit card account for any additional amounts incurred as a result of surcharges and/or services not covered by your insurance. We will contact you before charging your credit card.

No credit card information is ever stored on our servers. We use Stripe.com, one of the most secure and reputable payment processors available. All card numbers are encrypted on disk with AES-256. Decryption keys are stored on separate machines. None of Stripe's internal servers and daemons are able to obtain plaintext card numbers; instead, they can just request that cards be sent to a service provider on a static whitelist. Stripe's infrastructure for storing, decrypting, and transmitting card numbers runs in separate hosting infrastructure, and doesn't share any credentials with Stripe's primary services (API, website, etc.).

Print Full Name

Date

Signature

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Nutrition Questionnaire

First Name*

Middle Name

Last 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?

- ◯ Yes
- ◯ No

If yes, please specify

Physician Information

First Name

Last Name

Phone Number

Medications

Medical Conditions

Food allergies / intolerances

Is work stressful?

- ◯ Yes
- ◯ No

Do you smoke?

- ◯ Yes
- ◯ No

Do you drink?

- ◯ Yes
- ◯ No

Times per week you exercise

Type of exercise

Do you experience? (check all that apply)

- [ ] Headaches
- [ ] High Blood Pressure
- [ ] Fatigue
- [ ] Appetite Loss
- [ ] Stomach Problems
- [ ] Other

How is your energy throughout the day?

- ◯ High
- ◯ Moderate
- ◯ Low

Supplements

Special dietary products

How do you compensate for your stress?

Are there any foods you avoid?

Who shops for groceries?

Who does the cooking?

Typical Eating Habits

Breakfast

Mid-morning snack

Lunch

Afternoon snack

Dinner

Night snack