



Registered Dietitians  
www.livenutrition.com

**NUTRITION REGISTRATION INFORMATION** (Please Print)

LastName \_\_\_\_\_ First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_

STREET ADDRESS \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

MAILING ADDRESS \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

e-mail address \_\_\_\_\_

PHONE (H) \_\_\_\_\_ (W) \_\_\_\_\_ Mobile \_\_\_\_\_

BIRTHDATE \_\_\_\_\_ AGE \_\_\_\_\_ SS# \_\_\_\_\_ Sex \_\_\_\_\_ Marital Status \_\_\_\_\_

PRIMARY PHYSICIAN \_\_\_\_\_

Who referred you? Physician Health Practitioner Friend/relative Yellow pages Online Radio TV News WTBL other

Your EMPLOYER \_\_\_\_\_

Your OCCUPATION \_\_\_\_\_

**PRIMARY INSURANCE**

Policy Holder NAME \_\_\_\_\_ Policy holder SS# \_\_\_\_\_

Policyholder BIRTHDATE \_\_\_\_\_ Your RELATIONSHIP TO Policyholder \_\_\_\_\_

Policyholder EMPLOYER \_\_\_\_\_

**SECONDAY INSURANCE**

Policy Holder NAME \_\_\_\_\_ Policy holder SS# \_\_\_\_\_

Policyholder BIRTHDATE \_\_\_\_\_ Your RELATIONSHIP TO Policyholder \_\_\_\_\_

Policyholder EMPLOYER \_\_\_\_\_

I HEREBY,

- 1) CERTIFY THAT I HAVE RECEIVED A COPY THE HIPAA PRIVACY NOTICE
- 2) AUTHORIZE INSURANCE PAYMENTS TO BE SENT TO THE DIETITIAN IF APPLICABLE
- 3) CERTIFY THAT I AM FINANCIALLY RESPONSIBLE FOR ALL SERVICES RENDERED TO ME AND/OR MEMBERS OF MY FAMILY, IF INSURANCE DOES NOT REIMBURSE THE DIETITIAN
- 4) I CERTIFY THAT I HAVE RECEIVED AND AGREE TO THE PATIENT POLICIES
- 5) CERTIFY THAT I AM RESPONSIBLE FOR ANY LATE FEES IF MY COPAY IS NOT PAID AT THE TIME OF SERVICE, MY BALANCE IS NOT PAID WITHIN 30 DAYS AND/OR COLLECTION FEES OF 25% IF MY BALANCE IS NOT PAID IN 90 DAYS.

PATIENT/GUARDIAN SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

*All accounts with outstanding balances will be assigned for collection in 90 days unless other arrangements have been made.*

**48 HOUR CANCELLATION OF APPOINTMENTS REQUIRED TO AVOID CHARGE**

**WHAT ARE YOUR PERSONAL NUTRITION GOALS?** \_\_\_\_\_

**ANTHROPOMETRICS**

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ USUAL WEIGHT \_\_\_\_\_ WEIGHT GOAL \_\_\_\_\_

HIGHEST AND LOWEST WEIGHT (Adult Life) \_\_\_\_\_

**HEALTH HISTORY**

CURRENT MEDICAL AND HEALTH STATUS \_\_\_\_\_

PAST MEDICAL HISTORY (Please note any major illnesses or surgeries) \_\_\_\_\_

FAMILY MEDICAL HISTORY \_\_\_\_\_

MEDICATIONS (including dosage) \_\_\_\_\_

VITAMIN/MINERAL SUPPLEMENTS (including dosage) \_\_\_\_\_

DO YOU SMOKE? \_\_\_\_\_ IF YES, HOW MUCH PER DAY \_\_\_\_\_

DO YOU DRINK ALCOHOL? \_\_\_\_\_ IF YES, WHAT TYPE(S), HOW MUCH AND HOW OFTEN \_\_\_\_\_

DO YOU HAVE FOOD ALLERGIES/INTOLERANCES? \_\_\_\_\_

EXERCISE: PLEASE NOTE FREQUENCY, INTENSITY AND DURATION \_\_\_\_\_

**SHOPPING AND COOKING**

HOW MANY TIMES PER WEEK DO YOU EAT IN RESTAURANTS? \_\_\_\_\_

WHO DOES THE COOKING? \_\_\_\_\_ SHOPPING? \_\_\_\_\_

WHAT ARE YOUR FAVORITE FOODS? \_\_\_\_\_

NAME \_\_\_\_\_ DATE \_\_\_\_\_

## NOTICE OF PRIVACY PRACTICES: *Live 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 Margaret Davis at *Live 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 \_\_\_\_\_, 20\_\_\_\_ 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 LIVE NUTRITION**

I acknowledge receiving a copy of the Notice of Privacy Practices of Live Nutrition on \_\_\_\_\_ (insert date).

If patient read the Notice of Privacy Practices but refused to keep a copy, check here. ( )

Printed name of patient \_\_\_\_\_

Printed name of authorized representative \_\_\_\_\_  
(if applicable)

Signature or initials of patient or authorized representative \_\_\_\_\_

Comments of Live Nutrition regarding why written acknowledgement was not obtained:

\_\_\_\_\_

\_\_\_\_\_

## ***Live Nutrition – Practice Policies***

In order to meet your needs and provide you the best possible care in a timely and efficient manner, we ask you to honor the following guidelines:

- 1) Please respect your Nutritionist's time by ***arriving on time*** for your appointment and ***be prepared to leave on time***. We schedule based on a 50 minute hour for the first visit and by fractions of an hour thereafter. Please address all urgent questions at the start of your visit. Please have payment or copay ready at the start of your visit.
- 2) You must ***have your doctor send a referral*** to us prior to your first visit. Please allow 5 business days for the referral to reach our office.
- 3) You must bring your ***current insurance card*** on your first visit and to bring any new cards issued to you for any subsequent visit.
- 4) You must pay your ***copay*** at the start of the visit. Please have checks made out to your Nutritionist with the amount of your copay
- 5) Copays not received at the time of the visit will incur a \$15 additional charge if we have to bill for the copay.
- 6) All outstanding balances will be billed to you. Late fees will be incurred after 30 days. Your account will be sent to collection if not received in 90 days and will include any collection fees and late fees you have incurred.
- 7) You must complete and sign a Patient ***Registration Form*** with accurate and legible information including that of your spouse or parent if they are the policy holder. Please download and complete the Registration documents or allow 15 minutes prior to the time of your visit to complete the materials on the clipboard in the lobby.
- 8) Please record the date and time of your appointment. You will be charged for the full amount of your appointment ***if you miss your appointment*** or ***if you do not cancel*** your appointment 48 hours prior to your scheduled time.
- 9) Please bring copies of your most recent lab results or ask your doctor to fax them to us prior to your first visit. Please bring any blood glucose (sugar) results and your glucometer if you are testing your own levels.

Thanks for your cooperation!  
Maggie Davis, MS, RD, LDN, FADA, CDE  
Elizabeth Showalter, Administrative Assistant  
Linda Sheridan, Billing Manager