Total Nutrition℠ THERAPY, LLC

HOME VISIT NUTRITION COUNSELING

phone: 513.477.4270 • www.eatright123.com

REGISTRATION INFORMATION

First Name _____ Middle _____ Last Name _____

ADDRESS_____

City _____ST_____ Zip_____

E-mail _____

BIRTHDATE _____/_____/_____ AGE _____

PHONE (H) _____Work _____

PRIMARY DOCTOR _____ PCP Phone _____

How were you referred? Doctor Newspaper Friend/Family Nutrition Council Internet Anthem

Your EMPLOYER _____ OCCUPATION _____

If you can't make your appointment, please let us know as soon as possible so we can offer it to someone else. If you miss your appointment or cancel with less than 24 hours' notice we cannot re-allocate appointment slot, therefore 100% of the fee becomes payable. We reserve the right to charge for missed appointments.

Please note, you do not have to indicate your doctor's phone number if you do not want us to contact them. We consider it a courtesy to let your doctor know that you are receiving medical nutrition therapy. Please let us know if there is any part of this form that you do not feel comfortable with.

If someone other than the client is completing this form, please provide proof of authority to do so, in the form of a power of attorney or guardianship document.

NOTICE OF HIPAA PRACTICES

I acknowledge receiving a copy of the Notice of Privacy Practices of Total Nutrition Therapy, LLC on _____ (insert today's date).

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

Signature or initials of patient or authorized representative

_____

RESPONSIBILITY FOR PAYMENT

I, _____, agree to be fully and personally responsible for payment. Total Nutrition Therapy, LLC agrees to refund me any duplicate payments.

Signature or initials of patient or authorized representative

_____

I HEREBY,

I. CERTIFY THAT I HAVE RECEIVED A COPY OF THE HIPAA PRIVACY NOTICE

II. CERTIFY THAT I AM FINANCIALLY RESPONSIBLE FOR ALL SERVICES RENDERED TO ME.

III. I CERTIFY THAT I HAVE RECEIVED AND AGREE TO THE PATIENT POLICIES

IV. I CERTIFY THAT I WILL BE RESPONSIBLE FOR A $15.00 LATE FEE ON COPAYMENTS NOT PAID AT THE TIME OF SERVICE, AN ADDITIONAL 50% OF PAYMENT DUE IF DELINQUENT BY 45 DAYS IN ADDITION TO THE COST OF COLLECTION FEES. 100% OF VISIT WILL BE CHARGED FOR APPOINTMENTS NOT CANCELLED WITHIN 24 HOURS OF VISIT. A $35 FEE WILL BE ADDED TO BILL FOR ANY RETURNED CHECKS.

V. PACKAGES MUST BE USED WITHIN 9 MONTHS OF PURCHASE.

VI. NO REBATES FOR VISITS OR PACKAGES WILL BE PROVIDED.

SIGNATURE _____DATE_____

CLIENT DATA SHEET

FOR RD USE ONLY
IBW:_____ % IBW_____ ABW: _____BMI: _____
KCAL NEEDS: _____ / _____ kcals / kg

PLEASE COMPLETE THE FOLLOWING QUESTIONS:

WHAT ARE YOUR PERSONAL NUTRITION GOALS? _____
_____
Have you ever worked with a RD? _____ When: _____

HEALTH STATISTICS

HEIGHT _____ WEIGHT _____ USUAL WEIGHT _____

GOAL WEIGHT _____ HIGHEST WEIGHT SINCE AGE 18 _____LOWEST_____
ANY SIGNIFICANT WEIGHT CHANGES OVER THE PAST 6 MONTHS? _____
DO YOU HAVE ANY FOOD ALLERGIES / INTOLERANCES? _____

CURRENT MEDICAL AND HEALTH STATUS _____

_____
WHO DOES THE COOKING? _____ SHOPPING? _____

PAST MEDICAL HISTORY INCLUDING MAJOR ILLNESS AND SURGERIES
_____

_____

WHAT ARE YOUR FAVORITE FOODS? _____
_____

MEDICATIONS _____

_____

VITAMIN / MINERAL SUPPLEMENTS AND HERBAL PREPARATIONS _____

_____

DO YOU SMOKE? _____ IF YES, HOW MANY PER DAY? _____

DO YOU DRINK ALCOHOL? _____ IF YES, WHAT KIND, HOW OFTEN AND HOW MUCH AT THAT TIME? _____

DO YOU EXERCISE? IF SO WHAT, HOW LONG AND HOW OFTEN? _____

_____

HOW MANY TIMES A WEEK DO YOU DINE OUT OR PURCHASE FAST FOOD?

_____

WHAT FOODS DO YOU DISLIKE? _____

DIABETES: FASTING BLOOD SUGAR _____ 2 HOURS AFTER MEALS_____

HOW MANY TIMES A DAY DO YOU TEST? _____

24 Hour Diet Recall Form

Please be as specific as possible. Include all beverages, condiments, and portion sizes.

Time	Food Item and Method of Preparation	Amount Eaten	Where

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TOTAL NUTRITION THERAPY, LLC PRACTICE POLICIES

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

1. Please respect your Dietitians appointment **time limits** and be aware that we charge per hour of service unless otherwise indicated ($135.00 per hour).
2. You must **have your doctor send a referral** to us prior to your first visit if you would like to try for reimbursement from your insurance company. Referrals must include your diagnosis AND the doctor's full name. We can provide you with a Medical Nutrition Therapy statement to submit to your insurance company if desired. There is no guarantee that you will be reimbursed by your insurance company.
3. You must pay 100**%** of services rendered. You may pay via cash, check, or credit card made out to Total Nutrition Therapy, LLC.
4. All outstanding balances will be billed to you. Late fees will be incurred after 45 days. Your account will be sent to collection if not received in 45 days and will include any collection fees and late fees you have incurred.
5. Packages must be used within 9 months of purchase.
6. No rebates for visits or packages will be provided.
7. An additional 50% will be added to your balance if payment is delinquent by 45 days in addition to the cost of any collection fees. For all clients, the entire visit fee will be charged for appointments not cancelled within 24 hours of visit or no shows.
8. You must complete and sign a **Patient Registration Form** with accurate information. Please download, print, and complete the Registration documents prior to the first visit.
9. Please record the date and time of your appointment. You will be charged the full amount of your visit **if you miss your appointment** or if **you do not cancel your appointment 24 hours in advance**.
10. Bring copies of your most recent lab values or ask your doctor to fax them to us prior to your first visit. Please bring any blood glucose or AIC results with you (if applicable).

Telephone (513)-477-4270 Fax (859)-586-7017 Email: rd@eatright123.com

Notice of Privacy Practices

Keeping our client's personal health information secure is a top priority for us at Total Nutrition Therapy, LLC. While information is the cornerstone of our ability to provide superior MNT services, our most important asset is our client's trust. This notice tells you how we collect, handle, and disclose personal health information about you. If you want to limit our disclosing of this information, please submit your wishes to us in writing.

Our Policies and Practices to Protect Your Personal Health Information

We protect personal health information we collect about you by maintaining physical, electronic, and procedural safeguards that meet or exceed applicable law.

Protected Health Information We Collect and May Disclose

The protected health information we collect about you comes from the following sources:

- Information received from your physician or other healthcare provider.
- Information we receive from you while providing MNT services and on enrollment forms, assessment surveys, or other forms.
- Information we receive from other sources such as caregiver, insurer, employer and other third parties.

We may disclose any of your protected health information to the following entities as long as this information is directly related to health services or your individual care. These entities include doctors, hospitals, health care providers, pharmacies, insurance companies, family members or other persons involved directly in your individual care.

Protected health information will not be used for marketing, except if the communication is by a Total Nutrition Therapy, LLC staff member directly to you or to provide you with education or promotional material from Total Nutrition Therapy, LLC. PHI also includes when TNT is required to disclose information without your consent such as emergencies, by order of court, criminal activity, etc. If you have any questions please contact our privacy officer at 513-477-4270.

Revised 1/08