REGISTRATION FORM

DATE:
_____/_____/______

PATIENT INFORMATION:

Patient Name: ____

Address: ____

City: ____ State: ____________ Zip_______________

E-mail: ____

Telephone: (home) _________________________ (Work) __________________________________

Cell: _____________________________________

Sex: ___M ___F Date of Birth: _____/______/______

INSURANCE INFORMATION:

Insurance Co.: ____

ID#/Group#: ___________________________________ (Group): ____________________________________

Subscriber's Name: ____

Subscriber's DOB: _____/_____/______

Relationship to Patient: ____

Is patient covered by additional insurance? ___Yes ___No

2nd Insurance Co.: ____

ID#/Group#: ___________________________________ (Group): ____________________________________

Subscriber's Name: ____

Subscriber's DOB: _____/_____/_____

Relationship to Patient: ____

ASSIGNMENT AND RELEASE

I certify that I, and/or my dependent(s), have insurance coverage with ______________________________
(name of insurance company(ies) and assign directly to Nutrition in Motion all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I authorize the use of my signature on all insurance submissions. Nutrition in Motion may use my health care information and may disclose such information to the above named insurance company(ies) and their agents for the purpose of obtaining payment for services and determine insurance benefits or the benefits payable for related services. This consent will end when my current treatment plan is completed or one year from the date signed below.

Signature of Patient, Guardian or Personal Representative:

____

Please print name of Patient, Guardian or Personal Representative:

____

Date:________________________ Relationship to Patient: ____

PEDIATRIC INTAKE FORM

DATE: _____/_____/_____

WHO IS FILLING OUT THIS FORM? ❍ Child/Patient ❍ Guardian

NAME: ______________________________ RELATIONSHIP TO CHILD: ____________________

PATIENT NAME: ______________________________ PREFERRED NAME: ____________________

AGE: __________ HEIGHT: __________ WEIGHT: __________

REASON FOR APPOINTMENT/GOAL: ____

MEDICAL HISTORY - Check the following that you have been diagnosed with:

❍ ADD/ADHD	❍ Anemia	❍ Anxiety	❍ Autism (ASD)	❍ Celiac Disease
❍ Constipation	❍ Crohn's Disease	❍ Depression	❍ Diabetes: Type 1 or 2	❍ Diarrhea
❍ Eczema	❍ Headaches	❍ High Blood Pressure	❍ High Cholesterol	❍ Irritable Bowel (IBS)
❍ Kidney Disease	❍ Malnutrition	❍ Obesity	❍ SPD (Sensory Processing Disorder)	
❍ Underweight	❍ Cancer: ________________		Any others not listed: ________________	

Is the patient on any medications or supplements? ❍ Yes ❍ No If yes, please explain: ____________________

____

Does the patient have any food allergies or intolerances? ❍ Yes ❍ No If yes, please explain: ____________________

____

Does the patient have any current diagnosis or history of an eating disorder? ❍ Yes ❍ No Please Explain: __________

____

Does the patient exercise? ❍ Yes ❍ No ❍ Gym/PE Class ❍ School Sports ❍ Community Sports Clubs
❍ Other: ____

Does the patient have a medical condition preventing them from exercising? ❍ Yes ❍ No
If yes, please explain: ____

For females, has she started her menstrual cycle? ❍ Yes ❍ No When was her last menstrual cycle? ________________

SOCIAL HISTORY - Who lives in the home with the patient?

❍ Mother ❍ Father ❍ Siblings ❍ Grandparent ❍ Step Parent ❍ Step Siblings
❍ Other, who: ____

School Grade Level? ______________ Concerns about grades/performance in school? ❍ Yes ❍ No

How many hours of sleep at night? ________ What time does the patient wake up? ________ Fall asleep? ________

How many hours a day does the patient use electronic devices (Computer, phone, table, TV, etc)? ________________

DIET HISTORY

Does the patient eat 5 servings of fruit and vegetables every day? ❍ Yes ❍ No

Is the patient happy with their current weight? ❍ Yes ❍ No

Does the patient follow a special diet? ❍ Yes ❍ No If yes, please explain: ____________________________

Does the patient drink water? ❍ Yes ❍ No Beverages other than water: ____________________________

Does the patient eat snacks between breaks at school? ❍ Yes ❍ No Who prepares the meals at home? ____________

Are there specific foods the patient does NOT eat? ❍ Yes ❍ No If yes, please explain: ____________________

____

Is the patient on a tube-feeding or supplementation regimen? ❍ Yes ❍ No If yes, please explain: ________________

____

1505 Medical Center Drive
Wilmington, North Carolina 28401
910.239.3562

The following information is provided to avoid any misunderstandings of Nutrition in Motions policies and payment for professional services rendered.

- Nutrition in Motion has a 24 hour cancellation policy. No shows or cancellations within 24 hours of your appointment time will be charged a $75.00 fee.
- As a courtesy to our patients that show up on time for their appointment, all patients that are late to their appointment may have to forfeit any time missed and may be responsible for the full amount of their appointment.
- Nutrition in Motion has a $35.00 return check fee on all returned checks. Note: Criminal procedures may take place if patient has a history of this matter, please make sure you have sufficient funds before signing check.
- Bills that are not paid within 90 days will be sent to collections.
- It is the responsibility of the patient to read all instructions on all supplements, read all ingredients in all supplements and contact their health care provider in reference to any questions regarding medication or health concerns prior to taking any supplements. It is also the responsibility of the patient to confirm any and all exercise and nutrition recommendations with their health care provider.
- Nutrition in Motion may report information about patients in the aggregate but does not release the patient's name without patient consent.
- I agree to have my health information shared with the referring physician
- Nutrition in Motion reserves the right to charge a reasonable fee for any extra copies and fax services.
- I also give permission for Nutrition in Motion to leave a voice mail if needed with the phone numbers I listed on my patient registration form.
- I understand Nutrition in Motion Notice for Privacy Practice. I understand that a copy is available at check in for patients to review. I understand that I may request a copy of the Notice of Privacy Practice at any time.
- I agree to be seen as a patient with Nutrition in Motion and agree to the above policies for Nutrition in Motion to the best of my knowledge, the information I share with Nutrition in Motion and its employees is correct.
- At the time of class/one-on-one visit, if there is a taste test offered or samples available, I participate per my own wishes and do not hold Nutrition in Motion liable for anything.

I HAVE READ AND I COMPLETELY UNDERSTAND ALL OF NUTRITION IN MOTION POLICIES AS STATED ABOVE.

Signature ____ Date _____/_____/______

HIPPA Privacy Rule of Patient Authorization Agreement

Authorization for the Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.508(a))

I, _______________________________________ (Patient's Name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I understand that this information serves as:

- a basis for planning my care and treatment;
- a means of communication among the health professionals who may contribute to my health care;
- a source of information for applying my diagnosis and surgical information to my bill;
- a means by which a third-party payer can verify that services billed were actually provided;
- a tool for routine health care operations such as assessing quality and reviewing the competence of health care professionals.

I have been provided with a copy of the ***Notice of Privacy Practices*** that provides a more complete description of information uses and disclosures.

I understand that as part of my care and treatment it may be necessary to provide my Protected Health Information to another covered entity. I have the right to review this facility's notice prior to signing this authorization. I authorize the disclosure of my Protected Health Information as specified below for the purposes and to the parties designated by me.

Privacy Rule of Patient Consent Agreement

Consent to the Use and Disclosure of Protected Health Information for Treatment, Payment, or Healthcare Operations (§164.506(a))

I understand that:

- I have the right to review this facility's Notice of Information practices prior to signing this consent;
- that this facility reserves the right to change the notice and practices and that prior to implementation will mail a copy of any notice to the address I've provided, if requested;
- I have the right to object to the use of my health information for directory purposes;
- I have the right to request restrictions as to how my Protected Health Information may be used or disclosed to carry out treatment, payment, or healthcare operations, and that this facility is not required by law to agree to the restrictions requested;
- I may revoke this consent in writing at any time, except to the extent that this facility has already taken action in reliance thereon.

Signature of Patient or Legal Representative Witness: ____

Printed Name of Patient or Legal Representative Witness: ____

Date: _____________________________________

HIPAA Privacy Rule Receipt of Notice of Privacy Practices Written Acknowledgement Form

Acknowledgement of Receipt of Information Practices Notice (§164.520(a))

I, ____ (Patient's Name) understand that as part of my healthcare, this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment. I acknowledge that I have been provided with and understand this facility's **Notice of Privacy Practices** provides a complete description of the uses and disclosures of my health information. I understand that:

- I have the right to review this facility's ***Notice of Privacy Practices*** prior to signing this acknowledgment;
- this facility reserves the right to change their ***Notice of Privacy Practices*** and prior to implementation of this will mail a copy of any revised notice to the address I've provided, if requested.

Signature of Individual or Legal Representative Witness: ____

Printed Name of Individual or Legal Representative Witness: _____________________________________

Date: ______________________________________

FOR OFFICE USE ONLY

We attempted to obtain written acknowledgement of receipt of our ***Notice of Privacy Practices***, but it could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barrier prohibited obtaining the acknowledgement
- ☐ An emergency situation prevented us from obtaining acknowledgement
- ☐ Other (please specify)
  ____
  ____

Privacy Official: ____

Date: ______________________________________