NUTRITION IN MOTION REGISTRATION

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.: _____

Member ID#: _____ (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: _____

NUTRITION IN MOTION

1505 Medical Center Drive
Wilmington, NC 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. If you do not call our office within 24 hours prior to your appointment, you may be responsible for the full amount of your appointment, even though you do not attend the session.
- 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 may be considered for 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 abides by HIPAA Privacy Guidelines. 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.
- I authorize _____ to contact Nutrition in Motion on my behalf. This person may exercise my rights and make choices about my health information. This authorization remains in effect until the end of my treatment plan or my written request.
- 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 _____/_____/_____

NUTRITION IN MOTION MEDICAL HISTORY

DATE: _____/_____/_____

PATIENT NAME: _____

HEIGHT: _____ WEIGHT: _____

MEDICAL HISTORY

Check the following that you have been diagnosed with:

- ❍ High Blood Pressure
- ❍ High Cholesterol
- ❍ Diabetes: Type 1 or 2
- ❍ Anxiety
- ❍ Depression
- ❍ Hypothyroidism
- ❍ Cancer type: _____
- ❍ Back Problems
- ❍ Stomach Ulcers
- ❍ Migraines
- ❍ Anemia
- ❍ Sleep Apnea
- ❍ Fibromyalgia
- ❍ Osteoporosis

Any others not listed: _____

FAMILY MEDICAL HISTORY

Check those that apply. Circle which direct family member:

- ❍ High Blood Pressure Mother / Father
- ❍ High Cholesterol Mother / Father
- ❍ Diabetes Mother / Father
- ❍ Hyper/Hypothyroidism Mother / Father
- ❍ Cancer type: _____ Mother/Father
- ❍ Anemia Mother / Father
- ❍ Obesity Mother / Father
- ❍ Heart Disease Mother / Father
- ❍ Osteoporosis Mother/Father
- ❍ Nutrient Deficiency:_____ Mother/Father

Do you have a history of any eating disorder? (ie. Anorexia or Bulimia) _____

Please list any medications you are currently taking: _____

Please list any vitamins, herbs, or supplements you are currently taking: _____

From past 5 – 10 years: _____ Highest Weight _____ Lowest Weight

Are you currently exercising? _____Yes _____No

If yes, how often, how long, and what types? _____

What is your current occupation? _____

How many hours/week do you work? _____

Do you smoke? _____Yes _____No Do you drink? _____Yes _____No

If yes to either, how much and how often? _____

Have you ever been seen by a dietitian before? _____Yes _____No

If yes, how long ago? _____