Patient Registration

**DATE:**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name: | DOB: | | Age: | Sex: |
| Address/State/Zip code: | | | | |
| Phone #: | | Alternate phone#: | | |
| Occupation: | | Employer: | | |
| Education level: | | Marital Status: | | |
| Email: | | | | |
| Patient Social Security #: | | | | |

**If patient is under 18 years old or a dependent, please complete:**

|  |
| --- |
| Parent/Guardian name: Parent/Guardian DOB: |
| Parent/Guardian SSN: |
| Marital Status of parents: |

Physician

|  |
| --- |
| Primary care or referring physicians name: |
| Address: |
| Phone #: |

Insurance

|  |
| --- |
| Primary Insurance Company: |
| Insurance ID#: Copay $: |
| Primary Insurance Name: Birthdate: |
| Insured’s Employer: |
| Secondary Insurance Company: |
| Insurance ID#: Copay $: |
| Secondary Insurance Name: Birthdate: |
| Insured’s Employer: |

**Appointment Policies**

1. Payment for services, including copays are due at the time services are rendered.

2. Assignment is accepted only from those insurance companies for which we are a provider.

3. You are responsible to obtain a referral if your insurance policy requires one. You will not be seen if you do not have a referral. If you want to be seen without a referral then you agree to self-pay for the appointment at $125.00 for an initial appointment and $75.00 for follow-up appointments.

4. If your insurance denies coverage or payment you are financially responsible for the full cost of the visit.

5. If we are not a provider of your insurance upon payment for the appointment you will be provided a Superbill for you to submit to your insurance for you to be reimbursed.

6. Payment can be made via cash, checks, Master Card, Visa, American Express and PayPal.

7. There is a $50.00 fee for any returned/bounced checks.

8. Twenty-four (24) hour advance notice is required for cancellations or change of appointments to avoid a $50.00 fee.

9. You will not be seen if you have an outstanding balance.

10. Outstanding balances not paid 60 days from final invoice will incur a 40% non-payment fee to the balance. Your account will be sent for collection.

By signing below I have read, understood, and agree to these appointment policies.

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Print Name: Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Permission to Release Health Information**

I grant the right to Leslie Flory, RDN to release and/or obtain health information about \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (patient's name) to my third party payers and the following healthcare providers or persons:

Person completing this form: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Receipt of Privacy Practice Notice**

Please read the copy of Leslie Flory’s Notice of Privacy Practice. Your signature with date acknowledges you have received and read Leslie Flory’s Notice of Privacy Practices.

Person completing this form: ­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship to patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Print Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOWYOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact:

Leslie Flory, RDN

13919 Cristo Ct, Centreville VA 20120

571-449-7035

Leslie.Flory.Nutrition@gmail.com

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI), to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. Uses and Disclosures of Protected Health Information: Your protected health information may be used and disclosed by our organization, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the organization, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for coverage may require that your relevant protected health information be disclosed to the health plan to obtain approval for coverage.

Healthcare Operations: We may use or disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, case management, review the competence or qualification of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing and other activities.

We may use or disclose your protected health information in the following situations without your authorization: as Required By Law, Abuse or Neglect, Legal Proceedings, and/or Law Enforcement.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or this organization has taken an action in reliance on the use or disclosure indicated in the authorization.

Your Rights

The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Our organization is not required to agree to a restriction that you may request. If our organization believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, e.g., electronically.

You may have the right to have our organization amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints:

If you are concerned that we may have violated your privacy rights or you disagree with a decision we made about you may file a complaint with us by notifying the contact information at the beginning of this notice. We will not retaliate against you for filing a complaint. We support your right to the privacy of your health information.

PATIENT NAME: DATE:

Patient Information

|  |
| --- |
| Explain the reason for this visit and what you ultimately wish to accomplish: |

Medical Conditions/History

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Disease/Condition | Self | Family (Relation) | Disease/Condition | Self | Family (Relation) |
| Asthma |  |  | Headaches |  |  |
| Cancer (type) |  |  | Heart Attack |  |  |
| Cardiovascular Disease |  |  | High Cholesterol |  |  |
| Diabetes |  |  | Hypertension |  |  |
| Drug Dependency |  |  | Intestinal Problems |  |  |
| Eating Disorder |  |  | Menstrual Problems |  |  |
| Food Allergies |  |  | Mental Health Issues |  |  |
| Food Intolerances |  |  | Obesity |  |  |
| Kidney Disease |  |  | Osteoporosis |  |  |
| Other, Specify: |  |  | | | |

|  |
| --- |
| List all your current medical conditions: |

Medications, Supplements, Vitamins, Over the Counter Medications (list below or attach a list)

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Name of Medication | Dose | Pill or injection | When you take | Why you take |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

PATIENT NAME: DATE:

Weight Information

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Height: | | Weight: | | Desired weight: | Usual Weight: | |
| Are you concerned about your weight? No Yes, explain: | | | | | | |
| Have you tried to lose weight before? No Yes, explain: | | | | | | |
| When? | What approach | | # lbs lost? | How long weight loss lasted | | Why you stopped |
|  |  | |  |  | |  |
|  |  | |  |  | |  |
|  |  | |  |  | |  |

Family Weight/Eating Information

|  |
| --- |
| Explain about members in your family whom are overweight? |
| Family members underweight? |
| Family members on a diet: |
| Does your family eat together? No Yes If yes, when? |
| Describe family meals: |

Eating Habits No Yes

|  |  |  |
| --- | --- | --- |
| Do you experience times during which you eat uncontrollably? |  |  |
| Do you induce yourself to vomit or have you in the past? |  |  |
| Do you use or have used laxatives? |  |  |
| Do you hurt or harm yourself? |  |  |
| Do you have or had negative emotions or feeling? |  |  |
| Have you ever been diagnosed with an eating disorder? |  |  |
| Are you currently or have you received treatment for an eating disorder? |  |  |

No Yes

|  |  |  |  |
| --- | --- | --- | --- |
| Do you skip meals? |  |  | If yes, why? |
| Do you eat out? |  |  | Which meals?  How often do you eat out?  What restaurants do you choose? |
| Do you know how to cook? |  |  | Who prepares meals?  Who does the grocery shopping? |
| Do you snack? |  |  | If yes, when and what do you typically have? |

Eating Behaviors

No Yes No Yes

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Do you eat standing up? |  |  |  |  |  |
| Do you eat in the car? |  |  |  |  |  |
| Do you eat while watching TV? |  |  |  |  |  |
| Do you eat while reading/computer? |  |  |  |  |  |
| Do you prefer to eat alone? |  |  |  |  |  |
| Do you eat with others? |  |  |  |  |  |
| Do you read nutrition fact labels? |  |  |  |  |  |

|  |
| --- |
| What are your favorite foods/meals? |
| What foods do you avoid and why? |

No Yes

|  |  |  |  |
| --- | --- | --- | --- |
| Have you been advised by your physician to follow a specific diet? |  |  | If yes, what is the diet? |
| Are you currently following that diet? |  |  | If not, why?  If yes, then what changes? |

Physical Activity

|  |
| --- |
| Do you participate in physical activity? Yes No if no, explain?  If yes, describe activity, duration, and numbers of days/week: |

No Yes

|  |  |  |  |
| --- | --- | --- | --- |
| Do you drink alcohol? |  |  | #drinks/per week |
| Do you smoke cigarettes? |  |  | #cigarettes/day: |
| Do you smoke marijuana? |  |  | If yes, explain: |
| Do you use/have used illegal drugs? |  |  |  |