New Client Information, Waivers, and Cancellation Policy

Ward Dietetics LLC, Nutrition Therapy of Memphis
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http://www.nutritiontherapy.com

Date _____

Name _____ Birth date _____

Address _____ Apt. # _____

City _____ State _____ Zip _____

Home phone _____ Work phone _____ Cell phone _____

E-Mail _____

Marital Status Married □ Single □ Other □ _____ Sex M □ F □

PHYSICIAN INFORMATION-Referring Physician or Primary Care Physician (If applicable)

Name _____

Phone _____

Address_____

City _____ State _____ Zip _____

FEES and INSURANCE COVERAGE

Fees for services are due at the time services are rendered. I accept payment in the form of cash, check, PayPal or credit cards (Visa/MasterCard/Discover/American Express). Most Medical Nutrition Therapy are not covered by insurance companies, therefore we do not submit claims to insurance companies. Upon request, we can provide you with a superbill with the diagnostic codes required so that you can self-file a claim. If you submit a letter from your doctor with your claim, you may be more likely to receive reimbursement. If you choose to submit an insurance claim, any reimbursement should go directly to you as you will have already paid me directly for your services. _____ **Initial**

CANCELLATION POLICY

There is a 48-hour notice cancellation policy. Messages may be left on the weekend as well. If this notice is not provided, I understand that I will be charged for the cancelled appointment if 48 hours' notice is not provided and the appointment is not rescheduled within a week.

If I am canceling a previously paid for appointment as part of a package of sessions, I understand that I will forfeit the appointment already paid for when less than 48 hours' notice is provided and the appointment is not rescheduled within a week.

I understand that if I purchase a pre-paid package of nutrition appointments and do not follow through on those unused appointments, there is no refund. **_____ Initial**

HIPPA AUTHORIZATION AND COMMUNICATION POLICY

Computers and unencrypted email, texts, and e-fax communications can be relatively easily accessed by unauthorized people and therefore can compromise the privacy and confidentiality of such communications. If you communicate private or confidential information via unencrypted email, texts, e-fax or phone messages, I will view it as your agreement to take the risk that such communication may be intercepted. If you do not want me to contact you via email, please let me know in the initial session. In order to be compliant with HIPPA, please indicate your approval of being contacted by phone or e-mail to confirm your appointment as deemed necessary. **_____Initial**

Any communications or consultations are not intended to diagnose, treat, cure, or prevent disease or illness, or to substitute for the advice of a physician or other healthcare professional. Patients should always seek the advice of a physician regarding health conditions and before altering the diet, changing an exercise regimen, starting any new lifestyle treatments or supplements or making changes to existing treatment plan. **_____Initial**

Ward Dietetics LLC reserves the right to disclose information to sources that it deems necessary to protect your health. Additionally, if you have nutrition related medical condition, your primary care physician or specialist may receive documentation of your nutrition services unless you decline this correspondence. I understand my physician or appropriate health care provider will receive documentation and this is acceptable. **_____Initial**

I have read and accept these policies of Ward Dietetics LLC/ Nutrition Therapy of Memphis

Date _____Client signature _____

NUTRITION, HEALTH, and LIFESTYLE INFORMATION (please answer all that apply):

1. Please list
    - DOB / Age:
    - PMHx (Past Medical History):
    - Lab values (especially any abnormal):
    - Weight and height (may include wt history if pertinent):
    - Current medical problems, symptoms:

2. Goal of Medical Nutrition Therapy Appointment?

3. Any Gastrointestinal issues such as constipation / diarrhea / gas / bloating / reflux?

4. Any food allergies or foods that are not tolerated?

5. Following any particular diet or food restrictions? Describe:

6. Please provide a list of current medications and/or supplements including dosages, if applicable:

7. Are foods eaten in response to any particular emotion or stress? If so, please describe:

8. Involved in any leisure activity or structured exercise? If so, please describe:

9. Please describe any past diets you have tried:

10. How often do you eat carry out or restaurant food per week?

11. How often do you cook each week?

12. Any additional information that may be pertinent to the visit?

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