|  |  |  |  |
| --- | --- | --- | --- |
| Patient Name: First Click here to enter text.  | MiddleClick here to enter text. | LastClick here to enter text. | Preferred Phone Number:XXX-XXX-XXXX |
| Home Address:Click here to enter text. | Apt. NoClick he | City:Click here to enter text. | State:  | Zip Code:  |
| Age:  | Gender:Click here to enter text. | Race:Click here to enter text. | Date of Birth:XX/XX/XXXX |
| Occupation:Click here to enter text. | Marital Status:Click here to enter text. |
| Email address:Click here to enter text. | Cell/Other Phone:XXX-XXX-XXXX |
| Parent/Guardian Name & Relationship (if applicable):Click here to enter t ext. | Parent/Guardian Phone:XXX-XXX-XXXX |
| Primary Care Physician:Click here to enter text. | Address:Click here to enter text. | Phone:XXX-XXX-XXXX |
| Referred by (if applicable):Click here to enter text. | Phone:XXX-XXX-XXXX |
| Reason for Visit or Referral:Click here to enter text. |

**PATIENT REGISTRATION FORM**

**ViTL Nutrition & Fitness**

19125 North Creek Parkway, Suite 142

Bothell, WA 98011

425.329.2659

contact@ViTLnutrition.com

|  |  |  |
| --- | --- | --- |
| **Emergency Contact Name:**Click here to enter text. | Relationship:Click here to enter text. | Phone:Click here to enter text. |

**A message:** [ ] **can** [ ] **cannot be left on my preferred phone number.**

**How did you hear about VNF?** [ ] Internet [ ] Event [ ] Printed/posted ad [ ] Friend/Family [ ] Other (please list): Click here to enter text.

**PRIVACY CONSENT**

 ViTL Nutrition & Fitness (VNF) requires your consent to use and disclose your protected health information to carry out treatment and healthcare operations. If you would like a more detailed description of such uses and disclosures please refer to our Notice of Privacy Practices. You have the right to review our Notice of Privacy Practices before signing this Consent. The terms of the Notice of Privacy Practices of VNF may change from time to time. You can get a copy of our revised Notice of Privacy Practices by contacting our office at 425-329-2659. We will also post a copy of our current Notice of Privacy Practices in our office and on our website ([www.ViTLnutrition.com](http://www.ViTLnutrition.com)).

 You have the right to revoke this consent in writing and the revocation will be effective except to the extent VNF has acted in reliance on your consent.

 By signing below, I hereby consent to the use of my protected health information for treatment and health care operations and acknowledge receipt of a copy of this Consent if requested. I give VNF permission to send a summary note to my physician or referring doctor of my consultation here.

I understand the nature and purpose of nutrition counseling and that the results are not guaranteed. I understand that I am financially responsible for all charges and agree to pay for services.

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| **Patient Name:** | Click here to enter text. |

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| --- | --- | --- | --- |
| **Patient/Guardian Signature:** | Click here to enter text. | **Date:** | Click here to . |

**NOTICE OF PRIVACY PRACTICES**

**THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED**

**AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.**

**PLEASE REVIEW IT CAREFULLY.**

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

ViTL Nutrition & Fitness

19125 North Creek Pkwy, Suite 142

Bothell, WA 98011

425.329.2659

contact@ViTLnutrition.com

**ALL MEMBERS OF ViTL NUTRITION & FITNESS WILL FOLLOW THIS NOTICE.**

ViTL Nutrition & Fitness (VNF) understands that medical information about you and your health is personal, and we are committed to protecting this information.

Each time you visit a nutritionist at VNF, a record of the recommendations and services you receive is made. Typically, this record contains your symptoms, examinations, diagnoses, nutritionist notes, past treatments, plan for future care or treatment, and billing record.

This record serves as:

1. A basis for planning nutritional recommendations;
2. A means of communication among the health care professionals who contribute to your care;
3. A means by which you can verify that services billed were actually provided;
4. A tool for educating health professionals;
5. A source for information for public health officials; and
6. A tool for assessing and continually working to improve the service rendered.

This Notice applies to all of the records of your care generated by VNF.

This Notice will tell you about the ways we may use and disclose medical information about you. It also describes your rights and our obligations regarding the use and disclosure of medical information.

Notice of Privacy Practices – Page 1 of 2

**OUR RESPONSIBILITIES**

VNF shall:

1. Make every effort to maintain the privacy of your health information;
2. Provide you with notice of our legal duties and privacy practices with respect to information we collect and maintain about you;
3. Abide by the terms of this notice;
4. Notify you if we are unable to agree to a requested restriction; and accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

**THE METHODS WHICH WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU**

The following categories describe different ways we may use and disclose your Protected Health Information. The examples provided serve only as guidance and do not include every possible use of disclosure.

1. As Required by Law: We will disclose medical information about you when required to do so by federal or Washington laws or regulations.
2. To Avert a Serious Threat to Health or Safety: We may use and disclose medical information about you to medical or law enforcement personnel when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
3. For Treatment: We will use and disclose your Personal Health Information to provide, coordinate, or manage your health care and any related service. For example, we may share your information with your primary care physician or other specialists to whom you are referred for treatment purposes.
4. For Health Care Operations: We may use and disclose medical information about you for office operations. These uses and disclosures are necessary to run the VNF office in an efficient manner and ensure that all clients receive quality services.
5. Appointment Reminders: We may use and disclose medical information in order to remind you of an appointment. For example, VNF employees may provide a written or telephone reminder that your next appointment is coming up.

Notice of Privacy Practices – Page 2 of 2

**POLICIES**

**PAYMENT**

Payment for services is due at the time services are rendered, unless other arrangements have been made in advance. We accept MasterCard, Visa, Discover, American Express, cash, and checks.

There is a **$20 fee** for any returned checks. **All payments for a returned check and further payments will be due in cash or money order only.**

It is our policy to collect credit card information for all patients upon payment. If there is an outstanding charge, we will call or leave a message on the phone number you provide at least **2 business days** before charging the card, informing you of the amount and date to be charged. By signing this document, you authorize ViTL Nutrition & Fitness to charge the credit card for any and all charges relating to past due appointment fees, missed appointments, late cancellations, or supplements. A receipt will be mailed to you on the day the charge was made.

By signing below, you also agree to waive any charge-back rights in the event of a dispute. Requests for a refund must be submitted in writing along with all documentation in accordance with standard policy of company issuing credit card.

If your account is 60 days past due, it will be sent to a collections agency. A **percentage-based collections fee** will be issued.

**LATE CANCELLATIONS/NO-SHOWS**

A missed appointment or late cancellation results in lost time that could have been given to another person wanting to receive care. We require a **24 hour notice** to cancel and/or change appointments or a **$60 fee** will be issued. For a missed/no-show appointment, you will be charged for the **full appointment** time.

**REFERRALS & REIMBURSEMENTS**

If you choose to seek reimbursement from your insurance company, you may request a superbill to submit to your insurer. **Please note** that your insurance company **may or may not pay** for your visit.

In order to provide you with a superbill, we require the **proper referral information** from your physician. This includes the Diagnosis Code Form to be completed by the patient and physician. The Diagnosis Code Form can be found on the VNF website (<http://www.vitlnutrition.com/#!clientforms/c22t0>). It is your responsibility to obtain the proper referral **prior to your visit** and bring it with you. Please do not ask us to get your referral.

Thank you for your cooperation!

**I have read, understand, received a copy (if requested) and agree to these policies.**

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| **Patient Name:** | Click here to enter text. |

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| --- | --- | --- | --- |
| **Patient/Guardian Signature:** | Click here to enter text. | **Date:** | Click here to . |

**HEALTH HISTORY**

**ViTL Nutrition & Fitness**

19125 North Creek Parkway, Suite 142

Bothell, WA 98011

425.329.2659

contact@ViTLnutrition.com

Please complete this questionnaire as thoroughly as possible in order to aid your nutritionist during your appointment. Thank you for your help.

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| --- | --- | --- |
| **Last Name:** Click here to enter text. | **First Name:** Click here to enter text. | **MI:** Click here. |

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| **What goals do you have for today’s visit?** | Click here to enter text. |
| **Please list your major health/wellness concerns in order of importance** | Click here to enter text.Click here to enter text.Click here to enter text.Click here to enter text.Click here to enter text.Click here to enter text. |
| **How would you describe your general health?** | [ ] Excellent [ ] Very Good [ ] Good [ ] Fair [ ] Poor |
| **How would you describe your general nutrition?** | [ ] Excellent [ ] Very Good [ ] Good [ ] Fair [ ] Poor |
| **What treatment modalities have you explored?** | [ ] MD [ ] ND [ ] Acupuncturist [ ] Psychotherapist [ ] Psychiatrist [ ] Chiropractor [ ] Herbal Medicine [ ] Other (please list):Click here to enter text. |
|  |
| **Stress Level (1-10, 10 being highest):**Click here | **Energy Level (1-10, 10 being highest):**Click here |
| **How many hours of sleep do you get each night?**Click here to enter text. |
| **Women: Are your periods regular?** [ ] **Y** [ ] **N** [ ] **N/A** |
|  |
| **ALLERGIES/SENSITIVITIES** |
|  | **Allergies (Severe/Life Threatening)** | **Sensitivities (Mild/Moderate)** |
| **Food:** | Click here to enter text. | Click here to enter text. |
| **Drugs:** | Click here to enter text. | Click here to enter text. |
| **Environmental Sources:** | Click here to enter text. | Click here to enter text. |
| **Other:** | Click here to enter text. | Click here to enter text. |
| **MEDICATIONS & SUPPLEMENTS** Please list all medications and supplements you are taking, including prescriptions, over-the-counter medications, vitamins, minerals, herbs, and homeopathic remedies. Attach another page if needed. |
| **Name of medication**(such as Vitamin D, Synthroid, etc) | **Strength**(88mcg, etc.) | **Directions**(such as 1 tablet twice a day, as needed, etc) |
| [ ] Check if none |  |  |
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| Health History – Page 1 of 2 |  |  |
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| **PAST MEDICAL HISTORY**Please check box if you have ever had any of the following medical conditions. If a condition does not apply, leave blank. |
| [ ] Allergies[ ] Anemia[ ] Anxiety[ ] Arthritis[ ] Asthma[ ] Blood Transfusion[ ] Cancer[ ] Congestive Heart Failure[ ] Clotting Disorder[ ] COPD[ ] Depression | [ ] Diabetes[ ] Emphysema[ ] GERD[ ] Heart Attack[ ] Heart Murmur[ ] HIV/AIDS[ ] Hypertension[ ] Hyperlipidemia[ ] Irritable Bowel Syndrome/Disease[ ] Kidney Disease[ ] Meningitis | [ ] Nerve/Muscle Damage[ ] Osteoporosis[ ] Parkinson’s/Alzheimer’s[ ] Seizures[ ] Sickle Cell Anemia[ ] Stroke[ ] Substance Abuse[ ] Thyroid Disease[ ] Tuberculosis[ ] Ulcers[ ] Other (please list): |
| **Please list any surgeries or hospital stays you have had and their approximate date/year below:** |
| Click here to enter text. | **Date:** Click here to t. |
| Click here to enter text. | **Date:** Click here to en. |
| Click here to enter text. | **Date:** Click here to ente |
| **BOWEL MOVEMENTS**Click here to enter text.**(number) per** [ ] **day** [ ] **week**  |
| **Describe consistency:** [ ] Smooth & formed [ ] Hard [ ] Loose [ ] Oily [ ] Watery [ ] Other: Click here to enter text. |
| **Are they hard to pass?** [ ] Y [ ] N |
|  |
| **SOCIAL HISTORY** |
| **Do you use any of the following substances regularly?** | [ ] Coffee/Black tea/Cola [ ] Alcohol [ ] Recreational drugs [ ] Tobacco-Current/Past Packs per day:Clicddddk How long:Click here Quit:Click he |
| **Please mark those that apply:** | [ ] Single [ ] Married [ ] Significant other [ ] Divorced [ ] Other:Click here to enter text. |
| **Do you have children?** | [ ] Y [ ] N If YES, what are their ages: Click here to enter text. |
| **Do you exercise regularly?** | [ ] Y [ ] N |
|  |
| **DIET HISTORY** |
| **Do you have any dietary restrictions or are you on a medically prescribed diet?** | [ ] Y [ ] N If YES, please describe: Click here to enter text. |
| **What diets have you tried in the past?** | Click here to enter text. |

WARNING: This information is intended for the use of the entity or person to whom it is addressed. This information may be confidential and privileged; the disclosure of which is governed by applicable federal and state laws. If you are not the intended recipient you are hereby notified that any disclosure, dissemination, distribution, or copying of this information is STRICTLY PROHIBITED.

Health History – Page 2 of 2