Medical Nutrition Intake

www.dietitianheather.com

General Information

Date:

Name			
Preferred Name			
Date of Birth		Age:	Gender: ☐ M ☐ F
Genetic Background	☐ African American ☐ Native American ☐ Mediterranean	☐ Hispanic ☐ Caucasian ☐ Northern European	☐ Asian ☐ Other *(please note)*

Have you ever had a blood transfusion? **Y N**

Address		
Home Phone		
Cell Phone		
Work Phone		
Fax		
Email		
Best Way to Reach?		
Primary Physician	*Name:*	
	City:	*Phone:*
Secondary Physician	*Name:*	
	City:	*Phone:*
Referred by		

Notes:

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Complaints/Concerns

What do you hope to achieve in your visit?

If you had a magic wand and could erase three problems, what would they be? (list you three main health/nutrition concerns)	
1	
2	
3	

When was the last time you felt well?	

Did something trigger your change in health?	

What makes you feel better?	
What makes you feel worse?	
What is the lowest body weight that you have been comfortably able to maintain for at least 2 years in your adult life, since around age 30?	
Notes:	

Allergy Information

Please list FOOD allergies	
Please list NON-FOOD allergies	
What type of allergic symptoms do you experience?	

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Medical History

	Height:	Weight:	Waist:

Please check those health conditions that your doctor has diagnosed (provide the date of onset)

GASTROINTESTINAL	INFLAMMATORY/AUTOIMMUNE
☐ Irritable Bowel Syndrome	☐ Chronic Fatigue Syndrome
☐ Inflammatory Bowel Disease	☐ Rheumatoid Arthritis
☐ Crohn's Disease	☐ Lupus SLE
☐ Ulcerative Colitis	☐ Poor Immune Function *(frequent infections)*
☐ Gastric or Peptic Ulcer Disease	☐ Severe Infectious Disease
☐ GERD (reflux/heartburn)	☐ Herpes-Genital
☐ Celiac Disease	☐ Multiple Chemical Sensitivities
☐ Hepatitis C or Liver Disease	☐ Gout
☐ Other Digestive:	☐ Other:

CARDIOVASCULAR	METABOLIC/ENDOCRINE
☐ Heart Disease (heart attack)	☐ Diabetes ☐ Type 1 or ☐ Type 2
☐ Stroke	☐ Metabolic Syndrome (insulin resistance)
☐ Elevated Cholesterol	☐ Hypoglycemia
☐ Irregular heart rate – Pacemaker	☐ Hypothyroidism (low thyroid)
☐ High Blood Pressure	☐ Hyperthyroidism (overactive thyroid)
☐ Mitral Valve Prolapse/heart murmur	☐ Polycystic Ovarian Syndrome (PCOS)
☐ Other Heart & Vascular:	☐ Genetic Disorder: ________________________
	☐ Other:

RESPIRATORY		MUSCULOSKELETAL/PAIN	
☐ Asthma	☐ Bronchitis	☐ Osteoarthritis	☐ Fibromyalgia
☐ Chronic Sinusitis	☐ Emphysema	☐ Chronic Pain	☐ Migraines
☐ Pneumonia	☐ Tuberculosis	☐ Other:	
☐ Sleep Apnea	☐ Other:		

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Medical History (continued)

Please note any past or current injuries:

NEUROLOGICAL/MOOD		CANCER
☐ Depression	☐ Bipolar Disorder	☐ Cancer *(please describe type and treatment)*
☐ Anxiety	☐ ADD/ADHD	
☐ Autism	☐ Multiple Sclerosis	
☐ Seizures	☐ Other:	

OTHER *(use separate sheet if necessary)*

☐ Kidney stones	☐ Anemia	Please any other diseases or health conditions
☐ Eczema	☐ Urinary (UTIs)	
☐ Psoriasis	☐ Frequent Yeast	Have you ever had genetic testing? ☐ Y ☐ N If yes, please note type and results.
☐ Acne	☐ OTHER:	

MEDICATIONS (Please list all prescribed medications you are taking and note reason.)

Name:	*Reason:*
Name:	*Reason:*
Name:	*Reason:*
Name:	*Reason:*
Name:	*Reason:*
Name:	*Reason:*

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.) Motrin, Aspirin? ☐ Y ☐ N

Have you had prolonged or regular use of Tylenol? ☐ Y ☐ N

Have you had prolonged or regular use of acid-blocking drugs (Tagamet, Zantac, etc.)? ☐ Y ☐ N

Frequent antibiotics >3 times per year? ☐ Y ☐ N Long term antibiotics? ☐ Y ☐ N

PLEASE BRING BOTTLES (or pictures) OF ALL SUPPLEMENTS AND MEDICATIONS TO FIRST VISIT

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Environmental Information

Do you have known adverse food reactions or sensitivities? ☐ Y ☐ N	If yes, please describe symptoms.
Are you exposed regularly to any of the following? *(check all that apply)*	What is your occupation?
☐ Cigarette smoke ☐ Perfumes ☐ Auto exhaust/fumes ☐ Paint fumes ☐ Dry-cleaned clothes ☐ Mold ☐ Nail polish/hair dyes ☐ Pesticides ☐ Heavy metals ☐ Fertilizers ☐ Teflon Cookware ☐ Pet dander ☐ Aluminum Cookware ☐ Chemicals	Please note any regular exposure to harmful chemical/substances. Please not any past exposure to harmful chemicals/substances.
Do you use any recreational drugs? If so, please note.	

Readiness Assessment

Rate on a scale of 5 (very willing) to 1 (not willing)

In order to improve your health, how willing are you to:

Significantly modify your diet	☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Take several nutritional supplements each day	☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Keep a record of everything you eat each day	☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Modify your lifestyle (e.g., work demands, sleep habits, exercise)	☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Practice a relaxation technique	☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Engage in regular exercise/physical activity	☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1
Have periodic lab tests to assess your progress	☐ 5 ☐ 4 ☐ 3 ☐ 2 ☐ 1

How much on-going support and contact (e.g., telephone, e-mail) from the nutritionist would be helpful to you as you implement your personal health program?

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Lifestyle Information

Do you engage in moderate cardiovascular physical activity at least 3 days a week, for a minimum of 20 minutes duration? (brisk walking, jogging, hiking, cardio exercise classes, cycling, stair-climbing, etc.)

☐ Y ☐ N

ACTIVITY	TYPE/INTENSITY *(low-moderate-high)*	# DAYS/WEEK	DURATION *(minutes)*
Stretching/Yoga			
Cardio/Aerobics			
Strength Training			
Sports or Leisure			

Rate your level of motivation for including exercise in your life? ☐ Low ☐ Med ☐ High

Note any problems that limit your physical activity.

Do you smoke? ☐ Y ☐ N	How many years?
Packs per day?	2nd hand smoke exposure? ☐ Y ☐ N
Excess stress in your life? ☐ Y ☐ N	Easily handle stress? ☐ Y ☐ N

Daily Stressors: *Rate on a scale of 1 (low) to 10 (high)*

☐ Work____ ☐ Family____ ☐ Social____ ☐ Finances____ ☐ Health____ ☐ Other:____

Do you feel your life has meaning and purpose? ☐ Y ☐ N ☐ unsure	Do you believe stress is presently reducing the quality of your life? ☐ Y ☐ N
Average number of hours you sleep per night **during the week**?	Average number of hours you sleep per night **on weekends**?
Trouble falling asleep? ☐ Y ☐ N	Rested upon waking? ☐ Y ☐ N

Do you wake up during the night? ☐ Y ☐ N If yes, how many times?

Note the approximate times you generally wake during the night.

How would you rate the overall quality of your sleep? *low quality* 1 2 3 4 5 *high quality*

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Surgeries/Hospitalizations

Please list any surgeries or hospitalizations (include dates and your ages if known).

Family History

Please note any family history of the following diseases: *heart disease, cancer, stroke, high blood pressure, overweight, lung disease, kidney disease, diabetes, cancer, mental illness or addiction.*

Family Member:	*Health Condition:*
Family Member:	*Health Condition:*
Family Member:	*Health Condition:*
Family Member:	*Health Condition:*
Genetic Disorders Known:	

Notes:

Dental History

Do you have any silver/mercury amalgam fillings? ☐ Y ☐ N If **Y**, how many?

Do you have any ☐ Gold fillings ☐ Root canals ☐ Implants ☐ Bridges ☐ Crowns

Do you have any ☐ Tooth pain ☐ Bleeding gums ☐ Gingivitis ☐ Chewing problems

Do you visit a dentist regularly (twice per year)? ☐ Y ☐ N

Have you ever had an infection in your jawbone? ☐ Y ☐ N

TMJ: ☐ grinding teeth ☐ jaw clicking ☐ braces? If yes, what age ____ ☐ surgery ☐ jaw pain

Teeth: ☐ extraction? How many? _________ ☐ Which teeth are missing? (# or name)_______________

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Medical Symptoms Questionnaire (MSQ)

Name: **Date:**

Rate each of the following symptoms based upon your typical health profile for:

☐ *Past 30 days* ☐ *Past 48 hours*

Point Scale

0 – *Never* or *almost never* have the symptom
1 – *Occasionally* have it, effect is *not severe*
2 – *Occasionally* have it, effect is *severe*
3 – *Frequently* have it, effect is *not severe*
4 – *Frequently* have it, effect is *severe*

HEAD

____ Headaches
____ Faintness
____ Dizziness
____ Insomnia TOTAL _____

EYES

____ Watery or itchy eyes
____ Swollen, reddened/sticky eyelids
____ Bags, dark circles
____ Blurred or tunnel vision *(does not include near or far-sightedness)*

TOTAL _____

EARS

____ Itchy ears
____ Earaches, ear infections
____ Drainage from ear
____ Ringing /hearing loss

TOTAL _____

NOSE

____ Stuffy Nose
____ Sinus problems
____ Hay fever
____ Sneezing attacks
____ Excessive mucous

TOTAL _____

MOUTH/THROAT

____ Chronic coughing
____ Gagging/throat clearing
____ Sore throat, hoarseness
____ Swollen/discolored tongue, gums, lips
____ Canker sores **TOTAL _____**

HEART

____ Irregular /skipped beats
____ Rapid/pounding beats
____ Chest pain

TOTAL _____

SKIN

____ Acne
____ Hives, rashes, dry skin
____ Hair loss
____ Flushing, hot flashes
____ Excessive sweating

TOTAL _____

LUNGS

____ Chest congestion
____ Asthma, bronchitis
____ Shortness of breath
____ Difficulty breathing

TOTAL _____

DIGESTIVE TRACT

____ Nausea, vomiting
____ Diarrhea
____ Constipation
____ Bloated feeling
____ Belching, passing gas
____ Heartburn
____ Intestinal/stomach pain

TOTAL _____

JOINTS/MUSCLE

____ Pain or aches in joints
____ Arthritis
____ Stiffness/limited movement
____ Pain or aches in muscles
____ Feeling of weakness or tiredness

TOTAL _____

WEIGHT

____ Binge eating/drinking
____ Craving certain foods
____ Excessive weight
____ Compulsive eating
____ Water retention
____ Underweight

TOTAL _____

ENERGY/ACTIVITY

____ Fatigue/sluggishness
____ Apathy, lethargy
____ Hyperactivity
____ Restless leg
____ Jetlag

TOTAL _____

MIND

____ Poor memory
____ Confusion, poor comprehension
____ Poor concentration
____ Poor physical coordination
____ Difficulty making decisions
____ Stuttering or stammering
____ Slurred speech
____ Learning disabilities

TOTAL _____

EMOTIONS

____ Mood swings
____ Anxiety, fear, nervousness
____ Anger, irritability, aggressiveness
____ Depression

TOTAL _____

OTHER

____ Frequent illness
____ Frequent or urgent urination
____ Genital itch or discharge
____ Bone pain

TOTAL _____

GRAND TOTAL____

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INGESTION: Nutrition History

Have you ever had a nutrition consultation? ☐ Y ☐ N

Have you made any changes in your eating habits because of your health? ☐ Y ☐ N

Please describe.

Do you currently follow a special diet or nutritional program? ☐ Y ☐ N

Check all that apply.

☐ Low fat	☐ Low Carb	☐ High protein	☐ Low sodium
☐ No Gluten	☐ Vegetarian	☐ Vegan	☐ Diabetic
☐ No Dairy	☐ No Wheat	☐ Weight Loss	☐ Other ___________

How often to you weigh yourself?

Have you had any recent history of weight loss or weight gain? If so, please describe.

How many meals per day do you eat? How many snacks?

Do you avoid any particular foods? *If yes, describe.*	
If you could only eat a few foods a week, what would they be?	
How many meals do you eat out per week?	☐ 0-1 ☐ 1-3 ☐ 3-5 ☐ more than 5 per week

Check all the factors that apply to your current lifestyle and eating habits:

☐ Fast eater	☐ Family member have different tastes
☐ Erratic eating patterns	☐ Love to Eat
☐ Eating too much	☐ Eat because I have to
☐ Late night eating	☐ Have a negative relationship to food
☐ Dislike healthy food	☐ Struggle with eating issues
☐ Time constraints	☐ Emotional eater (stress, bored, etc.)
☐ Travel frequently	☐ Confused about food/nutrition
☐ Do not plan meals or menus	☐ Frequently eat fast foods
☐ Rely on convenience items	☐ Poor snack choices

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Current Eating Habits

Mark the meals you eat regularly: ☐ Breakfast ☐ Lunch ☐ Dinner ☐ Snacks

Where do you obtain your food from: ☐ home prepared from whole foods ____% ☐ organic ___%

☐ home prepared convenience food ____% ☐ eat out ____%

Mark how many times you eat or drink the following items **PER WEEK**:

___ Soda (regular)
___ Soda (diet)
___ Alcohol
___ Hot tea
___ Cold tea
___ Coffee (regular)
___ Coffee (decaf.)
___ Sugar in coffee
___ Coffee drinks
___ Sweetened drinks
___ Sparkling water
___ Purified water
___ Tap water
___ Fruit juice
___ Lemonade
___ Milk (cow)
___ Milk (goat)
___ Soy Milk
___ Rice Milk
___ Nut Milk
___ Herbal teas

___ Fast food
___ Candy
___ Ice cream
___ Pudding
___ Refined sugars
___ Tuna fish
___ Swordfish
___ Sushi/sashimi
___ Salmon/other fish
___ Lunch meats
___ Bacon
___ Hot dogs
___ Whole eggs
___ Red meat
___ Poultry
___ Tofu
___ Tempeh/Miso

Sweeteners:

___ Equal/Nutrasweet (Aspartame)
___ Splenda (sucralose)
___ Saccharin
___ Stevia/Xylitol

___ Dried fruit
___ Canned fruit
___ Fresh Fruit
___ Jelly/jam
___ Sweets (cookies)
___ Green Salads
___ Raw veggies

What kind?

___ Cooked veggies

What kind?

___ Potatoes
___ Yams/Sweet Potatoes
___ Popcorn
___ Cereals
___ Oatmeal
___ Bagels/pretzels
___ White bread
___ Sprouted Br.
___ Wheat Bread

___ Crackers
___ Pasta
___ Brown rice
___ White rice
___ Corn tortillas
___ Flour tortillas
___ Potato Chips
___ Tortilla Chips
___ Pizza
___Yogurt (plain)
___ Yogurt (sweet)
___ Prepared meals (Lean cuisine, etc.)
___ Microwave meals/soups
___ Restaurant meals (healthy)
___ Restaurant meals (unhealthy)
___ Airplane meals
___ Legumes (beans, lentils)

PLEASE ENCLOSE A THREE DAY FOOD RECORD (OR ONE DAY OF TYPICAL FOOD INTAKE) WITH EXACT PORTIONS. THIS IS VERY INFORMATIVE FOR YOU AND FUN TO LOOK AT. I ALSO REPEAT THIS AS TIME GOES BY SO YOU CAN SEE IMPROVEMENT!! DON'T EAT PERFECTLY ON THESE DAYS, JUST NORMAL.

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Fats and Oils

Please indicate how many times PER WEEK you eat the following fats/oils.

OMEGA 9 *(stabilizer)* ~50% of daily fat calories Oleic Fatty Acid	___ Almond Oil ___ Almonds/Cashews ___ Almond butter ___ Avocados ___ Peanuts ___ Peanut butter (natural/soft)	___ Olives ___ Olive Oil ___ Sesame Seeds/Tahini ___ Hummus (tahini oil) ___ Macadamia Nuts ___ Pine Nuts
OMEGA 6 *(controllers)* *Essential Fatty Acid Family* *~30% of daily fat calories* **LA** ➔ GLA ➔ DGLA ➔ AA	___ Eggs (whole), organic (AA) ___ Meats (commercial) (AA) ___ Meats (grass-fed, org) (AA) ___ Brazil nuts (raw) ___ Pecan (raw) ___ Hazelnuts/Filberts (raw) ___ Hemp Seeds	___ Evening Primrose (GLA) ___ Black Currant Oil (GLA) ___ Borage Oil (GLA) ___ Hemp Oil ___ Grapeseed Oil ___ Sunflower Seeds (raw) ___ Pumpkin seeds (raw)
OMEGA 3 *(fluidity/communicators)* *Essential Fatty Acid Family* *~10% of daily fat calories* ALA ➔ EPA ➔ DHA	___ Fish Oil capsule: ↑DHA ___ Fish Oil capsule: ↑EPA ___ Fish (salmon/fin-fish) ___ Fish (shellfish) ___ Flax seeds/meal	___ Flax Oil ___ UDO's DHA Oil ___ Algae ___ Greens Powder w/algae ___ Chia seeds
BENEFICIAL SATURATED *(structure)* *~10% of daily fat calories* Short Chain/Medium-chain Triglycerides	___ Coconut Oil ___ Butter, organic ___ Ghee (clarified butter) ___ Dairy, raw & organic	___ Meats, grass-fed ___ Wild game ___ Poultry, organic ___ Eggs, whole organic
DAMAGED FATS/OILS (promoting stress to cells & tissues) *Should be <5% (try to avoid)* Trans Fats Acrylamides Odd-Chain Fatty Acids VLCFA/damaged	___ Margarine ___ Reg. vegetable oils (corn, sunflower, canola) ___ Mayonnaise(Commercial) ___ Hydrogenated Oil (as an ingredient) ___ "Imitation" cheeses ___ Tempura	___ Doughnuts (fried) ___ Deep-fried foods ___ Chips fried in oil ___ Reg. Salad dressing ___ Peanut Butter (JIF, etc) ___ Roasted nuts/seeds ___ Non-dairy products

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INGESTION: Nutrition History (continued)

What are the top three dietary changes do you think would make the most difference in your overall health?	**1.** **2.** **3.**
How committed are you to making dietary changes in order to improve your health?	*not committed* **1 2 3 4 5** *very committed*

Please list all **nutritional supplements** you currently take daily. Please include brand names and amounts as well as any herbs/botanical products.

Do you drink alcohol? ☐ Y ☐ N If yes, how many drinks per week?

Do you drink coffee or other caffeinated beverages? ☐ Y ☐ N If yes, # daily?

Do you use artificial sweeteners? ☐ Y ☐ N If yes, which ones?

DIGESTION

Do you feel like belching or are you bloated after eating? ☐ Y ☐ N

Do you have (or had) any eating disorders? ☐ Y ☐ N If yes, please describe.

Bowel Movements: How often? _____________ Color? ______________ Consistency? _______________

Your Birth: ☐ Natural/vaginal ☐ C-Section	Were you breastfed as an infant (if known)? ☐ Y ☐ N

Please note anything additional about your nutrition/eating habits.

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Authorization for the Release of Information

I, the patient, hereby authorize the use or disclosure of my health information from the listed Health practitioner as described below to the requesting practitioner.

Patient Information

Name ____ Date of Birth ____________

Address ____

City _______________________________ State ____ Zip Code _______________

Phone __________________

Health Practitioner 1

Health Practitioner Name ____

Address ____

City _____________________________ State ___ Zip Code _______________

Phone __________________ Fax Number _______________

I authorize for **Heather Finley MS, RD, LD, CLT** to release and/or disclose the medical information as indicated below to the health care provider, entity, or person I have indicated above.

DURATION: This authorization shall become effective immediately and shall remain in effect until _______________(date), or for one year from the date of signature if no date entered.

REVOCATION: This authorization may be revoked in writing by the undersigned at any time prior to the release of information from the disclosing party. Written revocation will not affect any action taken in reliance on this authorization before the written revocation was received.

INITIAL and check the box for which types of information are to be released and/or disclosed:

_____ General Medical Information from _____________ to ___________ (dates)

_____ Laboratory Tests (serum, urine) from _____________ to ___________ (dates)

_____ Information regarding specific diagnosis or treatment from ________ to ________.

_____Other ____ Nutrition and Dental ________________________________

Requesting Practitioner Information

Heather Finley MS, RD, LD, CLT
txdietitianheather@gmail.com
626.898.3936

Patient Name (printed): ____________________________

____ Date: ______________________
Signature of Patient

ALL PATIENT INFORMATION IS HANDLED UNDER THE HIPPA PRIVACY ACT
CONFIDENTIAL / HIPPA Approved Form

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DIETITIAN HEATHER, LLC
1664 Keller Parkway Ste 103
Keller, TX 76248
NOTICE OF PRIVACY PRACTICES
Effective date: April 14, 2003

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.

OUR LEGAL DUTY AND COMMITMENT TO PRIVACY

The dietitians and staff at Dietitian Heather LLC are and have always been committed to maintaining the privacy of your protected health information, known as PHI. Because of the Health Care Information Portability and Accountability Act, known as HIPAA, we are now required by law to provide you with this Notice of Privacy Practices and of our legal duties regarding your PHI.USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

We provide each patient (and patient's parent, for patients under 18 years of age) with an authorization form to allow us to provide PHI to your other health professionals and your insurance company when it is necessary to coordinate your treatment, to obtain payment on your behalf or on behalf of one of your other health care providers, or for health care operations (the administration of this practice and our patient services).

We are also required or permitted to provide your PHI without additional authorization in the following situations: to you or your personal representatives upon request; when required by the Secretary of the Department of Health and Human Services and for public health activities; to our business associates; for certain incidental uses or disclosures; for face-to-face communications that we make with you regarding products or services; to provide gifts of nominal value to you or your family; to correctional institutions if you are an inmate; to help prevent or control communicable diseases; to your employer in limited circumstances, typically related to workplace injuries or medical surveillance; for reporting abuse, neglect or domestic violence; for health oversight activities authorized by law (such as civil or criminal investigations, audits, licensure and disciplinary proceedings, etc.); for judicial and administrative proceedings (such as in response to court orders or discovery requests); for law enforcement; to funeral directors, coroners and medical examiners; for purposes of organ, eye or tissue donation; to avoid a serious threat of harm to health and safety; for specialized governmental functions (e.g., military operations; national
security); for auditing purposes; for certain research studies; for workers' compensation purposes; for emergencies or disaster relief; to persons involved in your care or payment related to your care; for notification purposes with respect to your care, condition, location or death. We may also contact you about appointment reminders, treatment alternatives or with educational information regarding your health condition. In any other situation, we will ask for your written authorization before using or disclosing any of your PHI. If you sign an authorization to use or disclose information, you can later revoke that authorization to stop further uses and disclosures.

INDIVIDUAL RIGHTS

In most cases, you have the right to look at or obtain a copy of PHI that we maintain about you. We may charge a fee for costs related to your request. We may, under certain circumstances, deny your request but if we do, you can obtain a review of that denial by another licensed health care professional that we designate. You also have the right to receive an "accounting," which lists certain instances when we have disclosed PHI about you for reasons other than treatment, payment or healthcare operations. The request can cover a time period no longer than six years from the date of disclosure. Your first request in a 12-month period is free. After that, we may charge for costs related to additional requests. If you believe that information in your record is incorrect, or if important information is missing, you also have the right to request that we correct the existing information, or add the missing information. We have the right to deny such a request under certain circumstances.

You have the right to request that your health information be communicated to you in a confidential manner such as asking that we contact you at work rather than home. You may request that we restrict how we use or disclose information about you for treatment, payment or healthcare operations, or to persons involved in your care (except when specifically authorized by you, when required by law, or in emergency circumstances). We will consider your request for such restrictions, but are only bound by them if we agree to them. To exercise any of the rights described above, please make a request in writing to Heather Finley RD/LD at the address above.

CHANGES IN OUR NOTICE OF PRIVACY PRACTICES

We may change our privacy practices at any time and the new terms shall apply to all PHI about you that we have at the time of the change and to all PHI about you that we maintain in the future. If we make any material changes, we will change our Notice of Privacy Practices and post it in the waiting are of our office. The changes will not take effect until they are reflected in a revised Notice of Privacy Practices. You may request a copy of our Notices of Privacy Practices at any time.

COMPLAINTS

If you are concerned that we have violated your privacy rights, you may contact Heather Finley. You may also send a written complaint to the Secretary of the United States Department of Health and Human Services. You will not be retaliated against for filing a complaint.

ACKNOWLEDGMENT OF RECEIPT OF PRIVACY PRACTICES

Please sign and return this page. You may keep the Notice of Privacy Practices for your records.

Patient Name ________________________________ Date of Birth _____/_____/_____

Parent/Guardian Name (if patient is under 18)__________________________________

I acknowledge receiving a copy of the Notice of Dietitian Heather LLC's Privacy Practices on

_____/_____/_____.

____

Patient Signature (or Parent/Guardian signature if patient is under 18)

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Patient Financial Responsibility & Signature

This form authorizes Dietitian Heather, LLC to keep my credit card on file and manually charge the fee for service to this credit card number in the event that:

- Payment was not rendered at time of service (accidental oversight)
- I am not present to pay for a minor charge
- Heather provides consultation outside of sessions (billed per 15 minutes)
- I missed my scheduled appointment (see cancellation policy)
- I cancelled with less than or equal to 24 hours of notice
- I am on a repayment plan
- Non-payment of any outstanding bills of 30-days or greater. This includes non-payment of remaining balance due after insurance payments.
- A returned check by your bank. Credit card will be charged for cost of service as well as any applicable bank fees.

As of June 1, 2013 a credit card on file is required for all new patients to secure an appointment or for scheduling remote nutrition consultations.

By signing this form, you agree to the financial responsibilities stated above and authorize Heather Heefner Finley MS, RD, LD, CLT to charge the credit card below for 1) nutrition services rendered only if this is the payment method used and/or 2) if any of the about situations apply. I agree to pay $6.00 credit card convenience and processing fee.

Name on credit card: ______________________________

Type of credit card VISA MC Credit card number: ______________________________

Expiration Date: ______________________________

Security code (3-digit code on back of card): ______________________________

Billing address including zip code: ______________________________

Email address: ______________________________

Credit card receipts are delivered via email for remote counseling services unless otherwise requested. A superbill can also be provided for insurance purposes.

Signature: ______________________________

Date: ______________________________

CANCELLATION POLICY

If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed for the entire cost of your missed appointment.

A full session fee is charged for missed appointments or cancellations with less than a 24-hour notice unless it is due to illness or an emergency. A bill will be mailed directly to all clients who do not show up for, or cancel an appointment.

Thank you for your consideration regarding this important matter.

____

Client Signature (Client’s Parent/Guardian if under 18)   (Date)

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