

**Patient's Name:** \_\_\_\_\_  
Last First Middle

Address \_\_\_\_\_  
Street & Apt # City State Zip

Primary Phone \_\_\_\_\_ Alternate Phone \_\_\_\_\_

E-mail address \_\_\_\_\_ Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Referring Physician (if applicable): \_\_\_\_\_

**Note: Our office requires a doctor referral for patients with Medicare.**

**Emergency Contact**

Name and Relationship to Patient \_\_\_\_\_

Phone Number \_\_\_\_\_ Address \_\_\_\_\_  
Street & Apt # City State Zip

**Primary Health Insurance Company:** \_\_\_\_\_

Primary Policy Holder's Name \_\_\_\_\_  
Last First Middle

Primary Policy Holders DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Subscriber/Policy ID # \_\_\_\_\_ Group # \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Is Primary a Current Patient?  No  Yes

Referral Required?  No  Yes Co-pay?  No  Yes, amount \$ \_\_\_\_\_

**Secondary Health Insurance Company:** \_\_\_\_\_

Primary Policy Holder's Name \_\_\_\_\_  
Last First Middle

Primary Policy Holders DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

Subscriber/Policy ID # \_\_\_\_\_ Group # \_\_\_\_\_

Relationship to patient: \_\_\_\_\_ Is Primary a Current Patient?  No  Yes

Referral Required?  No  Yes Co-pay?  No  Yes, amount \$ \_\_\_\_\_

May we discuss your medical condition with another person? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, whom \_\_\_\_\_ Relationship \_\_\_\_\_



Patient Name: \_\_\_\_\_

Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_

<b>Family Medical History:</b> (please mark all that apply)		
<b>CONDITION:</b>	<b>FAMILY:</b>	<b>RECENT LABS/ADDITIONAL INFO:</b>
Heart Disease		
Stroke		
High Cholesterol		
Diabetes Type:		
High Blood Pressure		
Obesity/Overweight		
Cancer		
Gastrointestinal		
Food Allergies/Intol.		
Dietary Restrictions		
Other		
<b>Personal Medical History:</b> (please mark all that apply)		
<b>CONDITION:</b>	<b>SELF:</b>	<b>RECENT LABS/ADDITIONAL INFO:</b>
Heart Disease		
Stroke		
High Cholesterol		
Diabetes Type:		
High Blood Pressure		
Obesity/Overweight		
Cancer		
Gastrointestinal		
Food Allergies/Intol.		
Dietary Restrictions		
Other		
<b>MEDICATIONS:</b>		
<b>SUPPLEMENTS:</b>		

Name: \_\_\_\_\_

Birth date: \_\_\_\_/\_\_\_\_/\_\_\_\_

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**Reason for Nutrition Visit:**

- Improve overall health     Lose weight     Physician Referral     A friend or family member wanted me to come  
 Look better/feel better     Lower out-of-pocket expenses (medications/ insurance)     Other: \_\_\_\_\_

**Current Challenges to Improve Health:**

- Lack of time due to:                       Lack of motivation  
 Work Schedule                               Illness or physical limitations  
 Family Responsibilities                       Too expensive to eat healthy  
 Social Calendar                               Other: \_\_\_\_\_

**Hidden Sources of Extra Calories are most likely to come from:**

- Large portions                       Soda/ Other Beverages                       Eating when I'm not hungry (bored/ upset/ stressed)  
 Sweets                                       Eating while I'm cooking                       Eating while I'm watching TV  
 Chips     Alcohol     Fried foods  
 None identified                       Going out to eat                               Other: \_\_\_\_\_

**Current Readiness to Behavior Change:**

- I am ready to start making changes now.  
 I am ready to think about making changes.  
 I am not ready to make any changes to my current lifestyle.

**Best Food/Activity Habit:** \_\_\_\_\_

**Worst Food/Activity Habit:** \_\_\_\_\_

Patient Name: \_\_\_\_\_

Birth date: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_



## Health Assessment Questionnaire

For each question choose the answer which **best** currently describes your usual behavior:

1.	How many days a week do you eat breakfast?	
2.	How often do you eat between meals?	
3.	What is your usual pattern for the evening meal?	
4.	Which sources of protein do you eat <b>most</b> often?	
5.	I eat appropriate portion sizes:	
6.	I eat fruits and vegetables that are:	
7.	Which types of carbohydrates do you choose <b>most</b> often?	
8.	How often do you eat low-fat dairy products?	
9.	Which types of drinks you choose <b>most</b> often?	
10.	How much alcohol do you consume?	
11.	Does your work or daily activity primarily include the following?	
12.	How often do you exercise for 20 minutes or more each week?	
13.	How many hours of sleep do you typically get a night?	

**NOTICE OF HEALTHY DIETS, INC. PRIVACY PRACTICES**

\*\* We are required by law to provide you with our privacy practices and to notify you of our legal duties regarding your PHI\*\*

Healthy Diets Inc. is committed to upholding the regulations and guidelines of the Health Care Information Portability and Accountability Act (HIPAA). We are also committed to maintaining the privacy of your Protected Health Information (PHI).

**USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION**

Each patient/guardian is provided with a medical release form which allows 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 for health care operations. Healthy Diets Inc. is also required or permitted to provide your PHI without additional authorization in the following cases:

- When you or your personal representatives upon request;
- When required by the Secretary of the Department of Health and Human Services
- For face-to-face communications that we make with you regarding products or services;
- To correctional institutions if you are an inmate;
- To help prevent or control communicable diseases;
- For reporting abuse, neglect or domestic violence;
- For judicial and administrative proceedings;

**INDIVIDUAL RIGHTS**

In general, you have the right obtain a copy of your PHI. We may charge a fee for costs related to your request. We reserve the right to deny your request under certain circumstances.

You may request that we limit how we use or disclose information about you for treatment, payment or healthcare operations, or to persons involved in your care. 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 Kim Iles, Director of Operations.

**CHANGES IN OUR NOTICE OF PRIVACY PRACTICES**

We reserve the right 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. You may request a copy of our Notices of Privacy Practices at any time.

**ACKNOWLEDGEMENT OF RECIEPT:**

*Please sign and return this page. Please let us know if you would like a copy of our Privacy Practices for your records.*

I acknowledge receiving a copy of Healthy Diets, Inc. Privacy Practices on: \_\_\_\_\_(today’s date)

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

\_\_\_\_\_

Parent/Guardian Name (if patient is under 18): \_\_\_\_\_

Patient Date of Birth: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_



## Office and Financial Policies

In order to better serve our patients and to reduce confusion between our patients and Healthy Diets Inc., we have implemented the following policies:

- Your insurance policy is a contract between you and your insurance company. It is the patient's responsibility to determine if our services are covered under your benefit plan. Someone from our office may assist you in verifying benefits **but** ultimately you are financially liable for all services rendered. We will not become involved in disputes between you and your carrier.
- As a courtesy, if we are contracted with your insurance company we will file your insurance claim for you. If your insurance company does not pay the practice within a reasonable time, then you will be responsible for payment. We are contracted with the following companies: Blue Cross Blue Shield, Cigna, Medicare, Aetna, and United Health Care.
- At the time of service you are responsible for payment of all receivables (co-payment, co-insurance, remaining balances etc). In the event that your health plan determines any service to be "non-covered" you will be responsible for the complete charge. Please have your insurance card, Identification card, and payment ready at check-in.
- If you have insurance coverage with a plan that we do not participate with, you will be considered a self-pay patient. Payment is due at the time the service is rendered. Upon request, you will receive a receipt for your payment and a superbill. You may use this to file a claim with your insurance company.
- Patients who have a dictated amount of visits by their insurance company are responsible for keeping track of those visits. Any appointments after the allotted amount will be the patient's responsibility.
- It is your responsibility to keep your patient information up to date. Please remember to contact our office if your home address, telephone number, or email address changes. This will ensure that you receive any communications from our office in a timely manner.

If you have questions regarding our office and financial policies please contact us (919) 870-1001. We are dedicated to providing the best possible care and service to you. We regard your complete understanding of your financial responsibilities as an essential part of your care and treatment.

**I have read and understand the financial policy of the practice and agree to be bound by its terms. I also understand and agree such terms may be amended periodically by the practice.**

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Signature of Patient or Responsible Party if Minor

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Date



## Office Cancellation Policy

We will make every effort to provide a courtesy confirmation call or email to remind you of your appointment but keep in mind this service is a courtesy. Our office, as a policy, does not overbook appointments and we make every attempt to create a schedule which will remain, in most instances, on time. As a result your appointment time is reserved especially for you. In order to ensure that every patient has fair access to schedule a timely appointment, we have adopted the following policy towards last minute cancellations and no shows:

We expect our patients to inform us in a timely manner if an appointment needs to be changed. While your personal reasons may vary, the ultimate result of a late cancellation or no show is time that another patient was not given for their personal health needs.

For non-emergent circumstances, we expect you to call or email to cancel or reschedule your appointment with at least 24 hours notice. If compelling issues are present, please let the office know.

Emergencies do NOT include: forgetting the appointment, choosing to do something else/be somewhere else other than your appointment, traffic congestion, and other avoidable circumstances.

Our office respects and values your time. We ask that you please respect our time in return.

Failure to cancel or reschedule your appointment in a timely manner will result in the following payment prior to rescheduling:

**\$25 late cancellation fee**

**\$100 no-show fee**

Failure to pay your late cancellation or no-show fee within 90 days will result in your account being turned over to collections.

I understand the cancellation policy and agree to pay the missed appointment fee if I do not call to reschedule with 24 hours notice.

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Patient or Guardian Signature

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Date