

REGISTRATION INFORMATION

Today's date _____ Patient Name _____

Phone # _____ Email(optional) _____

Street (Physical) Address _____

City _____ State _____ Zip _____

Male _____ Female _____ Birthdate _____ Last 4 of Social Security# _____

Married _____ Single _____ Other _____ Student _____

Children (+ages) _____

Occupation _____ Employer _____

Primary Physician and location _____

Referred By (or how did you hear about us?) _____

Height _____ Current Weight _____ Usual Weight _____

Present Health Concerns; please list in order of significance

1. _____

2. _____

3. _____

4. _____

5. _____

What are your goals for your visit today? _____

Prescription Medications you take, with dosages _____

Vitamins or Supplements you take, with dosages _____

Are you interested in professional recommendations for supplements? _____

Please list any food or medication allergies _____

Do you have any chemical sensitivities? _____

Have you had any occupational exposure to noxious or hazardous substances? _____

Do you use strong chemicals in the home (disinfectant, cleaners, polish, wax, drain cleaner, varnish, insect spray)? _____

Do you use hairspray, nail polish, perfume, or other chemical cosmetics? _____

Please list any serious illnesses and hospitalizations _____

Please check all conditions that apply to you

- | | | |
|--|--|--|
| <input type="checkbox"/> asthma | <input type="checkbox"/> diabetes/pre-diabetes | <input type="checkbox"/> liver disease |
| <input type="checkbox"/> anemia | <input type="checkbox"/> excessive thirst | <input type="checkbox"/> muscle cramps |
| <input type="checkbox"/> acne | <input type="checkbox"/> Epstein-Barr | <input type="checkbox"/> menopause |
| <input type="checkbox"/> ADD/autism | <input type="checkbox"/> fibromyalgia | <input type="checkbox"/> numbness in hands/feet |
| <input type="checkbox"/> altered taste | <input type="checkbox"/> heart arrhythmias | <input type="checkbox"/> poor appetite |
| <input type="checkbox"/> allergies(seasonal) | <input type="checkbox"/> heart disease | <input type="checkbox"/> PMS/menstrual difficulties |
| <input type="checkbox"/> allergies (food) | <input type="checkbox"/> high cholesterol | <input type="checkbox"/> stroke |
| <input type="checkbox"/> autoimmune disease
(specify _____) | <input type="checkbox"/> hemorrhoids | <input type="checkbox"/> swallowing difficulty |
| <input type="checkbox"/> bad breath | <input type="checkbox"/> HIV | <input type="checkbox"/> thyroid problems(specify _____) |
| <input type="checkbox"/> blurred vision | <input type="checkbox"/> IBS | <input type="checkbox"/> unintentional weight loss |
| <input type="checkbox"/> bowel disease | <input type="checkbox"/> interstitial cystitis | <input type="checkbox"/> viral infections |
| <input type="checkbox"/> chronic fatigue | <input type="checkbox"/> kidney disease | <input type="checkbox"/> weight gain |
| <input type="checkbox"/> cancer(specify _____) | | |

Symptom Survey

Date:

Patient Name:

Patient Signature:

Please fill in the following form completely. Score every symptom based on your experience over the last 30 days. Using the SCALE OF SYMPTOM POINTS listed below, FILL IN the appropriate score in the corresponding field for EVERY symptom listed.

SCALE OF SYMPTOM POINTS:

If You Don't Suffer From This Ever or Almost Ever **LEAVE IT BLANK.**

●○○○ = 1 = Suffered OCCASSIONALLY (less than 2 times per week), symptom **wasn't severe**

○●○○ = 2 = Suffered FREQUENTLY (2 or more times per week), symptom **wasn't severe**

○○●○ = 3 = Suffered OCCASSIONALLY and symptom **was severe**

○○○● = 4 = **Suffered FREQUENTLY and symptom was severe**

CONSTITUTIONAL

- Fatigue (sluggish, tired)
- Hyperactive (nervous energy)
- Restless (can't relax/sit still)
- Sleepiness During Day
- Insomnia at Night
- Malaise (Feel Lousy)
- _____ TOTAL (0-24)

EMOTIONAL/MENTAL

- Depression
- Anxiety
- Mood Swings
- Irritability
- Forgetfulness
- Lack of concentration/focus
- _____ TOTAL (0-24)

HEAD/EARS

- Migraine (diagnosed)
- Headache (any kind)
- Earache
- Ear Infection
- Ringing in Ear
- Itchy Ears
- Discharge From Ears
- _____ TOTAL (0-28)

SKIN

- Blemishes, Acne
- Rashes, Hives
- Eczema
- "Rosy" Cheeks
- _____ TOTAL (0-16)

NASAL/SINUS

- Post Nasal Drip
- Sinus Pain
- Runny Nose
- Stuffy Nose
- Sneezing
- _____ TOTAL (0-20)

MOUTH/THROAT

- Sore Throat
- Swollen Throat
- Swelling of Lips/Tongue
- Gagging/Throat Clearing
- Canker Sores
- _____ TOTAL (0-20)

LUNGS

- Wheezing
- Chest Congestion
- Dry Cough
- Wet Cough
- _____ TOTAL (0-16)

EYES

- Red or Swollen Eyes
- Watery Eyes
- Itchy Eyes
- Dark Circles" or "Bags"
- _____ TOTAL (0-16)

GENITOURINARY

- Increased Urinary Frequency
- Painful Urination
- _____ TOTAL (0-8)

MUSCULOSKELETAL

- Joint Pains/Aching
- Stiff Joints
- Muscle Aches
- Stiff Muscles
- _____ TOTAL (0-16)

CARDIOVASCULAR

- Irregular Heartbeat
- High Blood Pressure
- _____ TOTAL (0-8)

DIGESTIVE

- Heartburn/Reflux
- Stomach Pains/Cramps
- Intestinal Pains/Cramps
- Constipation
- Diarrhea
- Bloating Sensation
- Gas (of Any Kind)
- Nausea, Vomiting
- Painful Elimination
- _____ TOTAL (0-36)

WEIGHT MANAGEMENT

- _____ **Record Actual Weight**
- Fluctuating Weight
- Food Cravings
- Water Retention
- Binge Eating or Drinking
- Purging (all methods)
- _____ TOTAL (0-20)

Family History: Please identify any family embers affected by the following

Allergies(environmental)_____	Eczema or hives_____
Arthritis_____	Food allergies_____
Anemia_____	Headaches_____
Asthma_____	Heart disease_____
Autoimmune Disease_____	Hepatitis_____
IBS or Bowel Disease_____	High cholesterol_____
Cancer_____	High blood pressure_____
Depression_____	Kidney disease_____
Diabetes_____	Osteoporosis_____
Eating disorders_____	Stroke_____

Other significant family history_____

Please list any other information you think it is important for the dietitian to know:

Primary Insurance Company_____

ID#_____ Group #_____ Plan Name_____

Patient Relationship to Insured: Self_____ Spouse_____ Child_____

Insured's name (if different from patient)_____

Insured's Date of Birth (if different from patient)_____

Secondary Insurance Company_____

ID#_____ Group #_____ Plan Name_____

Patient Relationship to Insured: Self_____ Spouse_____ Child_____

Insured's name (if different from patient)_____

Insured's Date of Birth (if different from patient)_____

CONSENT TO TREAT

Health care providers are required to advise patients of the nature of the treatment to be provided, the risks and benefits of the treatment, and any alternatives to the treatment. This consent addresses the treatment provided by Natural Progression Health & Nutrition.

As a Registered Dietitian, Natural Progression does not practice medicine nor prescribe or adjust medication. Nutritional counseling is not a substitute for medical care, but an important complement to most types of treatment.

Methods & Therapeutic Approaches:

The Nutrition Care Process is composed of four steps:

- (1) Assessment includes: Obtaining patient health and lifestyle history, current dietary habits, nutrition concerns, and using current medical diagnoses to develop an appropriate plan of care.
- (2) Problem Identification is defined as nutritional findings/problems related to: intake of energy, nutrients, fluids, bioactive substances; medical or physical condition; or knowledge, attitudes/beliefs, physical environment, food security, and food safety.
- (3) Nutrition Intervention is purposefully planned actions designed with the intent of changing a nutrition-related behavior, risk factor, environmental condition, or aspect of health status for an individual and may include: personalized meal plans, nutrient intake analysis, use of diet diaries, nutrition education and general advice, supplement recommendations, and referral to other health care practitioners.
- (4) Monitoring and Evaluation involves: follow up counseling to evaluate achievement of goals, assess need for further education, counseling, or intervention, effectiveness of prescribed treatment, and any changes in health status.

Risks Associated with Treatment include but are not limited to:

- Nutrition intervention is highly personalized and general recommendations will be tailored with the individual's circumstances in mind to eliminate risk of potentially harmful recommendations (for example, reduction of caloric intake for weight loss resulting in nutritional deficiencies).
- Some food sources of recommended nutrients may carry their own risks (for example, the presence of methylmercury in some omega-3 fatty acid-rich fish).
- Failing to follow or discontinuing recommended treatments may result in a negative outcome
- Nutritional supplements may be recommended or provided.

Potential Benefits Associated with Treatment:

- Disease prevention and reduction of risk for chronic, nutrition-related diseases
- Symptom relief from nutrition-related disorders
- Restoration to health and the body's optimal functioning capacity, increased sense of well-being
- Greater ability to apply lifestyle and wellness strategies

I acknowledge that I have discussed with my health care provider: the condition the treatment is to address, the nature of the treatment, the risks and benefits associated with treatment, and alternatives to treatment. I understand that I may ask questions regarding my treatment before signing this form and that I am free to withdraw my consent at any time. I recognize that no guarantees have been given to me by Natural Progression regarding cure or improvement of my condition. I understand that if I refuse or cancel services without consultation with Natural Progression and/or my physician I will make no claim against Natural Progression for harm or damages. I understand that a record will be kept of the health services provided to me and will not be released to others unless directed by me or my representative or otherwise permitted or required by law.

(Patient Name-printed)

(Patient Signature)

(Date)

Please initial after each number to acknowledge that you understand the liabilities and responsibilities of the cost of patient care under Kathleen Bundy, RD (dba Natural Progression) at the above address.

1. _____ I understand that it is my responsibility to know and understand my insurance policy and benefits.
2. _____ I understand that my health insurance is a contract between myself and the insurance company.
3. _____ I understand that insurance may not cover nutrition services for certain conditions or circumstances. Most insurance plans only cover nutritional counseling based on a physician referral.
4. _____ I realize that when Natural Progression Nutrition files my insurance that they are doing so as a service to me and that it is not a requirement.
5. _____ I am aware that by paying for all of the services rendered on the day the services are provided that I may receive a discount classified as TOS (time of service). Natural Progression will not bill my insurance in this case. Any generation of billing forms by Natural Progression will negate the TOS discount. I will be given a receipt which I can use to bill the insurance company myself for reimbursement.
6. _____ I understand that I am responsible for all bills incurred at this office and I agree to make financial arrangements with Natural Progression for any services not covered under my insurance plan.

I authorize any holder of medical or any other information about me to release to the social security administration and the centers for Medicare and Medicaid services or its' intermediaries or carriers, or to the billing agent of this provider, any information needed for this or a related medical claim. I permit a copy of this authorization to be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts the assignment.

(Patient Name-printed)

(Patient Signature)

(Date)

IF YOUR INSURANCE COMPANY FAILS TO PAY FOR SERVICES, YOU WILL BE RESPONSIBLE FOR THE PAYMENT

NOTICE OF PRIVACY PRACTICES

This notice describes how your medical information may be used and disclosed and how you can obtain access to this information as mandated by the Health Insurance Portability & Accountability Act of 1996 (HIPAA). Please review it carefully.

The details of this policy can be found posted in the clinic for a more complete description of the use and disclosure of my protected medical information

At Natural Progression Health & Nutrition, protection of your medical information is important. Your medical information is personal and protecting it is a legal and ethical priority. A record will be created of the personal history you provide and the care and services you receive. This record is necessary to provide you with quality care and to comply with certain legal requirements.

The law requires health care providers to:

- Keep your medical information private.
- Give you this notice describing your legal duties and rights regarding your medical information.
- Follow the terms of this notice in effect with your signature.

Health care providers have the right to:

- Change the *Notice of Privacy Practices* any time in the future. Before any significant changes are made, you will be provided with a revised copy of the notice. The terms of the new notice will be effective for all medical information that is kept, including information previously created or received before the changes.

Use and/or disclosure of your medical information may be used:

- To provide treatment by Natural Progression and to coordinate with other health care practitioners in the same clinic.
- In business and practice operations (ex. training purposes or appointment reminders)
- Obtain payment from third-party payers for health care services.
- Notify or assist in notifying a family member or personal representative. In the event that you become ill or need assistance, information about your location and general condition may be provided.
- In response to a court of administrative order, subpoena, discovery request, or other lawful process under certain circumstances.

Your individual rights:

- Look at or receive a copy of your medical information with a request in writing.
- Receive a list of instances in which I have disclosed health information about you aside from treatment (ex. Subpoena).
- Request, in writing, that I place additional restrictions on use or disclosure of your medical information. Your request will be considered, but there is no legal obligation to agree to the restrictions.
- Have a copy of this notice

My signature confirms that I have been informed of my rights to privacy regarding my protected health information under HIPAA and that I have been given the right to review and receive a more detailed copy of Notice of Privacy Practices under HIPAA.

(Printed Name)

(Signature)

(Date)

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Your personal health information may be used to obtain medical from other health care providers to proved comprehensive care. By signing this form, you authorize Kathleen Bundy, MS RD to view your labs, charts or other medical information and to use your personal information for the purpose of providing comprehensive medical care. Your medical records may be accessed at Sound Holistic Health or requests may be made for information from outside clinics or providers. Please fill out your personal information and sign; "From" will be filled in as needed.

(Name of patient) _____
(Birthdate)

(Street address) _____
(City) _____
(State) _____
(Zip)

I authorize the use and/or release of my protected medical information

TO:

FROM:

Kathleen Bundy RD
2804 Grand Ave #300
Everett, WA 98201

Ph: 425-258-463
Fax: 425-258-4644

(street address)

(city, state, zip code)

(fax)

Medical Information to be released:

- Complete chart record
- Chart Notes : All Specify:_____
- Labs/Reports: All Specify:_____
- Billing Records All Specify:_____
- Other:_____

I understand that unless revoked this authorization is valid for 90 days from the date of signing. I understand that I may revoke this authorization in writing at any time except to the extent that disclosure has already been made in accordance with this document. I understand that information disclosed under this authorization may be re-disclosed by the recipient. Federal privacy rules may not protect my health information once the re-disclosure is made

I understand that my healthcare information is protected by state and federal regulations that protect the confidentiality of this information and that my healthcare information may not be released or disclosed without my written authorization, unless otherwise provided for by law

I understand that I do not have to sign this form as a condition for receiving treatment, unless the purpose of my treatment is solely to disclose health information to a third party, and that I am entitled to a copy of this form at the time of signing.

(Signature) _____
(Date)