

Medical Nutrition Therapy Assessment Form

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

Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_  
(street) (city) (state) (zip)

Phone: \_\_\_\_\_ Email: \_\_\_\_\_

Primary Insurance: \_\_\_\_\_ Subscriber ID #: \_\_\_\_\_

Reason for today's visit: \_\_\_\_\_

What is your primary incentive to change? \_\_\_\_\_

Are you currently being treated for any medical conditions? \_\_\_\_\_ yes \_\_\_\_\_ no

If yes, please specify: \_\_\_\_\_

Current medications and/or supplements: \_\_\_\_\_

Healthiest food/activity habit: \_\_\_\_\_

Least healthy food/activity habit: \_\_\_\_\_

Are you currently following a specific diet? \_\_\_\_\_ yes \_\_\_\_\_ no

If yes, please specify: \_\_\_\_\_

What other diets or eating plans have you tried in the past, if any?

Are you currently exercising? \_\_\_\_\_ yes \_\_\_\_\_ no

If yes, list the type, duration and frequency of exercise. List any limitations.



**Policies and Practices to Protect Your Personal Health Information**

Custom Fit Nutrition and Wellness, LLC (CFNW) is committed to upholding the regulations and guidelines of the Healthcare Information Portability and Accountability Act (HIPAA). We are also committed to maintaining the privacy of your Protected Health Information (PHI). We protect your personal health information we collect about you by maintaining physical, electronic and procedural safeguards that meet or exceed applicable law.

Each client/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 or to obtain payment on your behalf. CFNW is also required or permitted to provide your PHI without additional authorization in the following cases: (i) when required by the Secretary of the DHHS, (ii) for face-to-face communications that we make with you regarding services, (iii) to help prevent or control communicable disease, (iv) for reporting abuse, neglect or domestic violence, or (v) for judicial and administrative proceedings.

**I acknowledge receiving a copy of Custom Fit Nutrition and Wellness, LLC's privacy practices.**

\_\_\_\_\_  
Signature of Client or Responsible Party if Minor

\_\_\_\_\_  
Date

**Office and Financial Policies**

In order to better serve our patients and to reduce confusion between our clients and CFNW, we have implemented the following policies:

- Your insurance policy is a contract between you and your insurance provider. It is your responsibility to determine if (and to the extent) our services are covered under your benefit plan.
- If we are contracted with your insurance provider, we will file your claim for you. If your insurance provider does not pay CFNW within a reasonable time, you will be responsible for payment.
- You are responsible for payment of all receivables (co-payment, co-insurance, remaining balances etc.) at the time of service. 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 your appointment. Acceptable payment includes cash or check.
- Payment is due at the time the service is rendered for self pay clients. Upon request, we can provide a superbill to submit to your insurance provider.
- In the event that a check is returned for insufficient funds, you will be charged \$25.00 in addition to any bank charges incurred.

**Cancellation Policy**

A minimum advance notification of 24 business hours or one business day (excludes Saturday and Sunday) is required for cancellation or rescheduling of all scheduled appointments. You will be charged a cancellation fee of \$50 if you fail to comply with this policy. Failure to pay your fee within 90 days may result in your account being turned over to collections.

**I have read and understand the financial policy and cancellation policy of the practice and agree to be bound by its terms.**

\_\_\_\_\_  
Signature of Client or Responsible Party if Minor

\_\_\_\_\_  
Date

