Custom Fit
NUTRITION AND WELLNESS, LLC

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