New Patient Form

Patient Information

Patient's full name: _____

Date of birth: _____

Sex (please circle): Male or Female

Street address (Include Apt #): _____

City, State, Zip code: _____

Home phone #: _____

Cell phone #: _____

E-mail address: _____

Primary Insurance Information

Insurance plan name: _____

Relationship to insured (Primary insurance holder, please circle): Self / Spouse / Child / Other

Member ID: _____

Group #: _____

Subscriber's name (Primary insurance holder): _____

Subscriber's date of birth (Primary insurance holder): _____

Secondary Insurance Information (If applicable)

Insurance plan name: _____

Relationship to insured (Primary insurance holder, please circle): Self / Spouse / Child / Other

(Continue on page 2)

Member ID: _____

Group #: _____

Subscriber's name (Secondary insurance holder): _____

Subscriber's date of birth (Secondary insurance holder): _____

Physician Information

Primary care physician name: _____

Primary care physician phone #: _____

Who referred you to our office: _____

Thank you!

Client Agreement

Patient's full name: _____

Date of birth: _____

Insurance

I authorize Whole Nutrition Center to release information to my insurance companies and to be paid directly by my insurance companies for services billed. I understand that it is my responsibility to know what my insurance plan covers, whether or not a referral or pre-authorization is required and if there are any limitations of coverage (number of allowed visits, covered diagnoses, etc). **If claims are denied for any reason**, I acknowledge that I am **responsible for the full amount** billed to insurance and authorize Whole Nutrition Center to charge the card on file.

Credit/Debit Card Authorization

I authorize Whole Nutrition Center to charge my debit/credit card on file for any applicable deductibles, co-pays, co-insurance, claim denials, out-of-pocket services, and no-show/late cancellation fees.

HIPAA

I have received a Notice of Privacy Practices explaining the Health Insurance Portability and Accountability Act (HIPAA).

Nutrition Services

I understand that the clinicians at Whole Nutrition Center are Dietitians/Nutritionists — not physicians — and they do not dispense medical advice nor prescribe treatment. Rather, they provide education to enhance my knowledge of health as it relates to foods, dietary supplements, and behaviors associated with eating. While nutritional and botanical support can be an important compliment to my medical care, I understand nutrition counseling is not a substitute for the diagnosis, treatment, or care of disease by a medical provider.

Telehealth / Telemedicine

I authorize Whole Nutrition Center to use the appropriate telecommunication technologies to conduct initial and follow-up nutrition assessments for the purpose of improving client care. The information will be used for evaluation, treatment, education, and development of individualized lifestyle plans.

Cancellation / No-Show Policy

I agree to pay $40 for missed appointments if I do not call 862-309-9859 at least 24 hours prior to my appointment to cancel or reschedule. This charge is irrespective of the reason for the cancellation / no-show and is not covered by insurance.

Payment

I understand that all co-payments and other self-pay fees are due at time of service. Returned checks will incur a flat $40 fee. Balances unpaid after 90 days may be sent to collections.

BY SIGNING BELOW I AM AGREEING THAT I HAVE READ, UNDERSTOOD AND AGREE TO THE ITEMS CONTAINED IN THIS DOCUMENT.

Signature: _____

Date: _____

Credit/Debit Card Form

Cardholder's name: _____

Card number: _____

Expiration date: _____

Security code (CVV): _____

Billing Zip code: _____

**A credit/debit card is required to reserve your appointment. This card may be used for no-show/late cancellation fees and applicable co-pays and deductibles.*

HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date: February 2021

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this notice, please contact Sara Rivera via phone (862)309-9859 or email sara@wholenutritioncenter.com.

OUR PLEDGE REGARDING PROTECTED HEALTH INFORMATION

We at Whole Nutrition Center understand that protected health information about you and your health is personal. We are committed to protecting health information about you. This Notice applies to all records of your care generated by Whole Nutrition Center whether made by our personnel or your personal doctor.

This Notice will tell you about the ways in which we may use or disclose protected health information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of protected health information. Federal law requires us to:

Make sure that protected health information that identifies you is kept private;
Notify you about how we protect protected health information about you;
Explain how, when, and why we use and disclose protected health information; and
Follow the terms of the Notice that is currently in effect.

We are required to follow the procedures in this Notice. We reserve the right to change the terms of this Notice and to make new Notice provisions effective for all protected health information that we maintain by:

Making copies of the revised Notice available upon request; and
Posting the revised Notice on our Web site.

HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU

The following categories describe different ways that we may use and disclose protected health information without your written authorization.

For Treatment. We may use protected health information about you to provide you with, coordinate, or manage your medical treatment or services. We may disclose protected health information about you to doctors, nurses, technicians, medical students, or other Whole Nutrition Center personnel, including persons outside of our office who are involved in your medical care.

Whole Nutrition Center may also share protected health information about you in order to coordinate your care for such reasons as prescriptions or lab work.

We may use and disclose protected health information to contact you as a reminder that you have an appointment with Whole Nutrition Center. We may use and disclose protected health information to tell you about or recommend possible treatment options, treatment alternatives, or health-related benefits or services that may be of interest to you.

For Payment for Services. We may use and disclose protected health information about you so that the treatment and services you receive at Whole Nutrition Center may be billed to and payment may be collected

from you, an insurance company, or a third party. For example, we may need to give your health plan information about nutrition services you received at Whole Nutrition Center so your health plan will pay us or reimburse you for the service. We may also tell your health plan about the nutrition services you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations. We may use and disclose protected health information about you for Whole Nutrition Center health care operations, such as our quality assessment and improvement activities, case management, coordination of care, business planning, customer service, and other activities. These uses and disclosures are necessary to run the facility, reduce health care costs, and make sure that all of our clients receive quality care.

For example, we may use protected health information to review our treatment and services or to evaluate the performance of the dietitian who is providing your services. We may also combine protected health information about many Whole Nutrition Center clients to decide what additional services we should offer, what services are not needed, and whether certain treatments are effective.
Subject to applicable state law, the law allows or requires us to use or disclose your health information without your authorization in some limited situations for purposes beyond treatment, payment, and operations.

As Required by Law. We will disclose protected health information about you when required to do so by federal, state, or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose protected health information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

We may also disclose protected health information about you to a government authority if we reasonably believe that you are a victim of abuse, neglect, or domestic violence. We will only disclose this type of information to the extent required by law, and we will only disclose it if (a) you agree to the disclosure, or (b) the disclosure is allowed by law and we believe it is necessary to prevent or lessen a serious and imminent threat to you or another person.

Judicial and Administrative Proceedings. We may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made, either by us or the requesting party, to tell you about the request or to obtain an order protecting the information requested.

Business Associates. We may disclose information to business associates who perform services on our behalf (such as billing companies). However, we require that these associates appropriately safeguard your information. Our business associates are obligated to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract.

Public Health. As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Health Oversight Activities. We may disclose protected health information to a health oversight agency for activities authorized by law. These activities include audits, investigations, and inspections, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Law Enforcement. We may release protected health information as required by law, or in response to an order or warrant of a court, a subpoena, or an administrative request. We may also disclose protected health information in response to a request related to identification or location of an individual, a victim of crime, a decedent, or a crime on the premises.

Special Government Functions. If you are a member of the armed forces, we may release protected health information about you if it relates to military and veterans activities. We may also release your protected health

information for national security and intelligence purposes, protective services for the President, and medical suitability or determinations made by the Department of State.

Coroners, Medical Examiners, and Funeral Directors. We may release protected health information to a coroner or medical examiner. This release may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose protected health information to funeral directors, consistent with applicable laws, to enable them to carry out their duties.

Worker's Compensation. We may disclose protected health information as necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Food and Drug Administration (FDA). We may disclose to the FDA, or persons under the jurisdiction of the FDA, protected health information relative to adverse events with respect to drugs, foods, supplements, products, and product defects, or postmarketing surveillance information to enable product recalls, repairs, or replacement.

YOU CAN OBJECT TO CERTAIN USES AND DISCLOSURES

Unless you object, or request that only a limited amount or type of information be shared, we may use or disclose protected health information about you in the following circumstances:

We may share with a family member, relative, friend or other person identified by you protected health information that is directly relevant to that person's involvement in your care or payment for your care. We may also share information to notify these individuals of your location, general condition, or death.

We may share protected health information with a public or private agency (such as the American Red Cross) for disaster relief purposes. Even if you object, we may still share this information if necessary under emergency circumstances.
If you would like to object to use and disclosure of protected health information in these circumstances, please call or write to the contact person listed on page 1 of this Notice.

YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU

You have the following rights regarding protected health information that we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy protected health information that may be used to make decisions about your care or payment for your care. If we maintain your protected health information electronically, you can request that we provide access in an electronic form and format that is readily producible, or in a form and format agreed to by us.

To inspect and copy protected health information that may be used to make decisions about you, you must submit your request in writing to Sara Rivera. If you request a copy of the information, we may charge a fee for the costs of copying, mailing, or supplies associated with your request. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We will respond to your request no later than 30 days after we receive it. There are certain situations in which we are not required to comply with your request. In these circumstances, we will respond to you in writing, stating why we will not grant your request and describe any rights you may have to request a review of our denial.

Right to Amend. If you feel that protected health information we have about you is incorrect or incomplete, you may ask us to amend or supplement the information.

To request an amendment, your request must be made in writing and submitted to Sara Rivera. In addition, you must provide a reason that supports your request. We will act on your request for an amendment no later than 60 days after we receive it.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In these circumstances, we will provide a written denial stating why we will not grant your request. In addition, we may deny your request if you ask us to amend information that:

Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;

Is not part of the protected health information kept by Whole Nutrition Center

Is not part of the information that you would be permitted to inspect and copy; or

We believe is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of protected health information about you.

To request this list of disclosures, you must submit your request in writing to Sara Rivera. You may ask for disclosures made within the six years before your request. The first list you request within a 12-month period will be free. For additional lists in that 12-month period, we may charge you for the costs of providing the list. We are required to provide a list of all disclosures except the following:

Disclosures made for your treatment;

Those used for billing and collection of payment for your treatment;

Those related to health care operations;

Those made to you or requested by you, or those that you authorized;

Those that occurred as a byproduct of permitted use and disclosures;

Those used for national security or intelligence purposes, or provided to correctional institutions or law enforcement regarding inmates;

Those that were a part of a limited data set of information that does not contain information identifying you.

Right to Request Restrictions. You have the right to request a restriction or limitation on the protected health information we use or disclose about you for treatment, payment, or health care operations, or to persons involved in your care.

We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment, the disclosure is to the Secretary of the Department of Health and Human Services, or the disclosure is required by law.

To request restrictions, you must make your request in writing to Sara Rivera.

Right to Request Confidential Communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to Sara Rivera. We will accommodate all reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice at any time. To receive a paper copy, contact Sara Rivera.

Right to Receive Notice of Breach. You have a right to be notified upon a breach of any of your unsecured protected health information.

Rights for Out-of-Pocket Payments. If you paid out of pocket in full for a specific item or service, you have a right to ask that your protected health information with respect to that item or service not be disclosed to a

health plan for purposes of payment or health care operations. We are required to agree to your request unless the disclosure is otherwise required by law.

TYPES OF USES AND DISCLOSURES REQUIRING AN AUTHORIZATION

Most uses and disclosures of psychotherapy notes require us to obtain an authorization from you. In addition, in most instances, we cannot use or disclose your protected health information for marketing purposes or sell your protected health information without your written authorization. Finally, any other use or disclosure not described in this Notice will be made only with your authorization. Any time you provide us with a written authorization, you may revoke it any time in writing, to the extent that we have not already taken action in reliance on your previous authorization.

OTHER USES AND DISCLOSURES

We will obtain your written authorization before using or disclosing your protected health information for purposes other than those described in this Notice (or as otherwise permitted or required by law). You may revoke this authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your information, except to the extent that we have already taken action in reliance on the authorization.

YOU MAY FILE A COMPLAINT ABOUT OUR PRIVACY PRACTICES

If you believe your privacy rights have been violated, you may file a complaint with Sara Rivera or file a written complaint with the Secretary of the Department of Health and Human Services. A complaint to the Secretary should be filed within 180 days of the occurrence or action that is the subject of the complaint. If you file a complaint, we will not take any action against you or change our treatment of you in any way.

CHANGES TO THIS NOTICE

We reserve the right to change this Notice and make the new Notice apply to health information we already have, as well as any information we receive in the future. We will post a copy of our current Notice in our office. The notice will have the effective date clearly marked at the top of the first page.

HIPAA Acknowledgement

By signing below, I acknowledge that I have been provided with the opportunity to read your HIPAA Notice of Privacy Practices.

I also acknowledge that I have reviewed your HIPAA Notice of Privacy Practices.

Full name: _____

Signature (Patient/Guardian): _____

Date: _____

Intake/History Form

*Recent Labwork Results (Please upload recent labwork to the patient portal or email to Sara@wholenutritioncenter.com)

*Reminder- for patients interested in body composition testing please visit www.wholenutritioncenter.com/body-composition to review pre-test instructions

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If any of the following sections do not apply, please type "N/A or None"

What is your date of birth? _____

Who referred you to our office? _____

Medical History and Current Medical Conditions:

Doctors Contact Information: _____

Medication (please list the medication brand, dosage and what condition you are using it for):

Supplements (please list the supplement brand, dosage, and what you are taking it for):

Do you have a therapist?_____

Food Allergies, Intolerances or Sensitivities:

Current height and weight: _____

Personal Goals and reason for seeing the dietitian:

Other (Any information you would like your dietitian to know):

Whole Nutrition Center
25 Pine St. Suite 4, Rockaway NJ 07866
Tel: 862-309-9859 Fax: 908- 509-6734
admin@wholenutritioncenter.com

CONSENT TO RECORD AUDIO

HOW IT WORKS

Your clinician uses a digital Note Taker to create an accurate and timely record of your care. Instead of writing notes by hand, the session will be recorded which allows clinicians to give you their undivided attention during your time together. This means better care and more meaningful conversations between you and your clinician.

AUDIO RECORDING

It's important for you to know that your voice and conversation with your clinician are recorded to document the appointment.

DATA STORAGE

As soon as the audio is transcribed (usually a few seconds after the appointment ends), the audio recording is **permanently deleted.**

PRIVACY AND SECURITY

The recording process complies with the Health Insurance Portability and Accountability Act (HIPAA)

VOLUNTARY PARTICIPATION

If you still have any questions or concerns, your clinician would be happy to discuss this with you. You have the right to withdraw your consent at any time (even temporarily).

SIGNATURE

By signing this document, I agree to let my clinician record our appointment audio to document my care.

Patient's Full Name: _____

Date: _____

Signature: _____