FINANCIAL AGREEMENT

ANY CHANGES MADE TO THIS FORM ARE NULL AND VOID

Please remember that insurance is considered a method of reimbursing the patient for fees paid to the medical provider and is *not* a substitute for payment. My agreement with the insurance company is between my insurance company and I.

I understand it is my responsibility:

- For knowing the terms, regulations, and limitations of my insurance plan.
- For obtaining referrals when they are required by my insurance plan for coverage.
- To pay any deductible, co-insurance or non-covered amount not paid by my insurance plan for care provided to me or my dependent.

Optimize Nutrition makes no guarantee of insurance coverage or insurance payments. If my insurance company does not cover nutrition services, I will be billed for the full balance and payment is due upon receipt.

Payment: Payment for services and products is expected to be paid at the time of nutrition services. Cash and personal check are currently accepted at this time. I agree to pay for services rendered to the patient at the time of service or upon receipt of the first statement mailed by Optimize Nutrition. I promise to pay my account when due, and if collection procedures are required for unpaid balances, I am responsible for all costs of collections including, but not limited to, collections fees (generally 30-50%), interest at eighteen percent (18%) per annum from the last date of payment, and any court costs.

Returned Checks: I will pay a $35 fee for a returned check in addition to my full balance, with cash or credit card, within 10 days of being notified by Optimize Nutrition.

Missed or Cancellation of an Appointment: Missed appointments not canceled or rescheduled 24 hours ahead of time will be charged $50.

Signature: _____ Date: _____

LIABILITY FORM FOR NUTRITION SERVICES

This form is an important legal document. It explains the risks you are assuming in beginning a nutrition program. It is critical that you read and understand it completely. After you have done so, please sign your name and date in the spaces below.

Nutrition Disclaimer

The nutrition advice given by Optimize Nutrition" is solely based on the information provided by the client/individual. The nutrition information given is meant only for the client / individual completing the nutrition questionnaire form. It is the sole responsibility of the client / individual to provide complete and provide accurate information. Any misinformation, inaccurate or omitted information may affect the nutritional assessment and/or advice. Any misrepresented information is solely the client's / individual's responsibility. "Optimize Nutrition" will not be liable. "Optimize Nutrition" provides nutrition counseling only and is not licensed to prevent, diagnose, alleviate or treat any medical conditions, disease, physical or mental ailments or pain or infirmities.

Nutrition Waiver and Covenant Not to Sue

I have volunteered to participate in a nutrition program under the direction of "Optimize Nutrition" which will include, but may not be limited to nutrition planning. In consideration of "Optimize Nutrition" agreement to assist me, I do here and forever release and discharge and hereby hold harmless "Optimize Nutrition", and their respective agents, heirs, assigns, contractors, and employees from any and all claims, demands, damages,
rights of action or causes of action, present or future, arising out of or connected with my participation in any nutrition program including any injuries resulting there from. I acknowledge and agree that no warranties or representations have been made to me regarding the results I will achieve from this program. I understand that results are individual and may vary.

Nutrition Assumption of Risk

I recognize that specific foods may create allergic and possible fatal reactions, most specifically, products containing nuts. I have therefore specified any food allergies/ sensitivities I am aware of. I am aware that specific foods may interact with certain medications. I have discussed such food reactions and the side effects of all of my medications with my doctor or pharmacist and do not hold "Optimize Nutrition" responsible for food and medication reactions. I also understand the diet plan I receive will not take my medications into consideration. If I am on medications, I am responsible to consult with my doctor before starting a new diet plan. If I am pregnant or lactating, have high cholesterol, high blood pressure, high blood sugar, diabetes, renal disease, gastric by-pass surgery a family history of gout or any other medical condition that requires special dietary restrictions, I must receive permission from my physician before participating in the specific nutrition program designed for my use, or may be advised to seek help from another health professional.

Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW PROTECTED MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED.

This notice covers all information in our written and electronic records about your health. Optimize Nutrition's dietitians and staff may use and disclose medical information (Protected Health Information -- PHI) about an individual for medical treatment, payment and health care operations.

Optimize Nutrition is permitted, or required under specific circumstances, to use or disclose protected health information without the individual's written authorization, including but not limited to: disclosures required by law, disclosures to avert serious threats to health or safety, disclosures with reference to workers compensation, or disclosures to public health authorities (as examples, but not limited to the Food and Drug Administration (FDA), the Centers for Disease Control and Prevention, and the Occupational Safety and Health Administration (OSHA)).

Other uses and disclosures will be made only with the individual's written authorization and the individual may revoke such authorization. Optimize Nutrition's office policy is to contact the individual by phone, SMS, or email to provide appointment reminders; or information about treatment or other health-related benefits and services that may be of interest to the individual or patient. Optimize Nutrition will routinely contact patients by telephone, SMS, or email at home and/or at work; and, otherwise unless requested, may leave messages on the appropriate answering or messaging service regarding appointments, test results, etc. Our patients have the following rights regarding their protected health information (PHI):

A. The right to request restrictions on certain uses and disclosures of protected health information; however, Optimize Nutrition is not required to agree to a requested restriction.
B. The right to receive confidential communications of protected health communication.
C. The right to inspect and copy protected health information.
D. The right to amend protected health information.
E. The right to receive an accounting of disclosures of protected health information.
F. The right to obtain a paper or electronic copy of this Notice.

Optimize Nutrition is required by law to maintain the privacy of protected health information and to provide individuals with notice of its legal duties and privacy practices with respect to protected health information. Optimize Nutrition is required to abide by the terms of the Notice currently in effect. Optimize Nutrition reserves the right to change the terms of this Notice. The new Notice provisions will be effective for all protected health information that it maintains. Optimize Nutrition will provide individuals with a revised Notice per request.

OptimizeNutrition

IT FITS YOUR LIFE

Client Nutrition History Form

Client Name: _____ Gender: _____

Date of Birth: _____ Marital Status:_____

Address: _____City: _____State: _____
Zip:_____

Home Phone #:_____ Cell Phone #:_____Work Phone #: _____

E-mail Address: _____

Patient's Employer: _____Occupation: _____

Address: _____ Business Phone: _____

How did you find out us:_____

Referring Physician/ Phone Number:_____

Emergency Contact: _____ Relationship: _____

Phone#:_____

What would you like to learn during our session?

_____

What are your nutrition goals?

_____

_____

How would you rate your readiness to change?
1 (very resistant) 2 3 4 5 6 7 8 9 10 (very motivated)

Medications:_____

Vitamin, Mineral, Herbal Supplements:_____

List any Food Allergies:_____

Are you experiencing any problems with the following?

Nausea Vomiting Taste Changes Heart Burn/Reflux

Lack of Appetite Chewing/Swallowing Difficulty Diarrhea Constipation

Family History: Do you or any family members have the following health conditions?

Diabetes	Self	Parent	Grandparent	Other
Heart Disease	Self	Parent	Grandparent	Other
High Blood Pressure	Self	Parent	Grandparent	Other
Stroke	Self	Parent	Grandparent	Other
Obesity	Self	Parent	Grandparent	Other

Other family history:_____

Surgery History: _____

Describe your quality of sleep: _____

How many hours_____/night

Naps: Yes/No _____ Daily _____ Weekends Only _____ Sporadically

Have you ever tried to change your diet? If so, why?

_____

_____

Do you crave any foods? _____

Do you have religious/cultural beliefs that affect your diet? _____

Meal Patterns- How many days a week do you:

a. **Eat breakfast?**
   0-1 days/wk 2-3 days/wk 4-5 days/wk 6-7 days/wk

b. **Eat dinner with friends and/or family?**
   0-1 days/wk 2-3 days/wk 4-5 days/wk 6-7 days/wk

c. **Eat Fast-Food meals?**
   0-1 days/wk 2-3 days/wk 4-5 days/wk 6-7 days/wk

d. **Eat meals or snacks in the car?**
   0-1 days/wk 2-3 days/wk 4-5 days/wk 6-7 days/wk

e. **Eat meals or snacks in front of the TV?**
   0-1 days/wk 2-3 days/wk 4-5 days/wk 6-7 days/wk

Physical Activity- how many days per week do you:

a. **Participate in physical education (if in school)?**
   0-1 days/wk 2-3 days/wk 4-5 days/wk 6-7 days/wk

b. Participate in physical activity (walk, ride bike, play games) for a total of 60 minutes?

0-1 days/wk 2-3 days/wk 4-5 days/wk 6-7 days/wk

How many hours per day do you:

a. Watch TV?

Less than 1 hr 1-2 hours 3-4 hours 5 or more

b. Use a computer/smart phone/video games?

Less than 1 hr 1-2 hours 3-4 hours 5 or more

Are you concerned about your weight: Yes No

Estimated daily water intake: _____

Do you skip meals? If so, which meal, and how often?

_____

Is there a particular meal that you have trouble with and why?

_____

How many meals do you eat out per week?

_____

Where do you commonly eat out? List all that apply.

_____

Current Height_____

Current Weight_____

Weight History

Highest weight known	Weight _____	Age/Year_____
Lowest weight over past year	Weight _____	Age/Year_____
Weight one month ago	Weight _____	Age/Year_____
Weight 6 months ago	Weight _____	Age/Year_____

How do your friends/family influence your eating patterns? _____

_____

Who do you find supportive?

_____

How often do you eat or drink the following foods/beverages?

Fruits:				
I eat fresh fruit…	Daily	Several Times/week	Seldom	Never
I eat canned fruit…	Daily	Several Times/week	Seldom	Never
I eat dried fruit…	Daily	Several Times/week	Seldom	Never
I drink juice…	Daily	Several Times/week	Seldom	Never
Vegetables:				
I eat fresh vegetables…	Daily	Several Times/week	Seldom	Never
I eat frozen vegetables…	Daily	Several Times/week	Seldom	Never
I eat canned vegetables…	Daily	Several Times/week	Seldom	Never
Grains:				
I eat whole grains…	Daily	Several Times/week	Seldom	Never
I eat white flour products…	Daily	Several Times/week	Seldom	Never
I eat beans/green peas…	Daily	Several Times/week	Seldom	Never
I eat corn…	Daily	Several Times/week	Seldom	Never
I eat potatoes/sweet potatoes…	Daily	Several Times/week	Seldom	Never
Dairy:	Daily	Several Times/week	Seldom	Never
Yogurt:	Daily	Several Times/week	Seldom	Never
Cheese:	Daily	Several Times/week	Seldom	Never
Soy Products:	Daily	Several Times/week	Seldom	Never
Meat:				
I eat beef…	Daily	Several Times/week	Seldom	Never
I eat pork…	Daily	Several Times/week	Seldom	Never
I eat chicken…	Daily	Several Times/week	Seldom	Never
I eat fish…	Daily	Several Times/week	Seldom	Never
I eat eggs…	Daily	Several Times/week	Seldom	Never
Fats:				
I eat butter/margarine…	Daily	Several Times/week	Seldom	Never
I use oils…	Daily	Several Times/week	Seldom	Never
I use salad dressing…	Daily	Several Times/week	Seldom	Never
I eat nuts…	Daily	Several Times/week	Seldom	Never
I eat peanut butter…	Daily	Several Times/week	Seldom	Never
Sweets:				
I eat sweets…	Daily	Several Times/week	Seldom	Never
I use Artificial Sweeteners…	Daily	Several Times/week	Seldom	Never
Beverages:				
I drink milk…	Daily	Several Times/week	Seldom	Never
What kind of milk?_____				
I drink regular soda…	Daily	Several Times/week	Seldom	Never
I drink diet sodas…	Daily	Several Times/week	Seldom	Never
I drink alcohol…	Daily	Several Times/week	Seldom	Never
If so, what type? _____				
I drink coffee…	Daily	Several Times/week	Seldom	Never
What do you add to your coffee? _____				
I drink tea…	Daily	Several Times/week	Seldom	Never
What do you add to your tea? _____				
I drink regular water…	Daily	Several Times/week	Seldom	Never

Daily Food Record

Time of Day	Type of Food or Beverage (brand name, description of food)	Amount Consumed	Comments
