# Nutrition Intake Information - Child

**General Information:** **Date Completed:** _______________

**Child's Name**: ______________________________ Date of Birth: ___________ SS#: ___________________
Child's Address: ____________________________________________
____________________________________________

With whom does the child reside? ______________________________________________________________

**Guardian's Name**:______________________________ DOB: __________ Relationship to child:_____________
❑ Address same as child's or __________________________________________________________________
Email Address: ____________________________________________ Okay to contact via email? ❑ yes ❑ no
Cell: _______________________Okay to leave voicemail? ❑ yes ❑ no Okay to text? ❑ yes ❑ no
Home: _______________________Okay to leave voicemail? ❑ yes ❑ no
Work: _______________________Okay to leave voicemail? ❑ yes ❑ no

**Guardian's Name**:______________________________ DOB: __________ Relationship to child:_____________
❑ Address same as child's or __________________________________________________________________
Email Address: ____________________________________________ Okay to contact via email? ❑ yes ❑ no
Cell: _______________________Okay to leave voicemail? ❑ yes ❑ no Okay to text? ❑ yes ❑ no
Home: _______________________Okay to leave voicemail? ❑ yes ❑ no
Work: _______________________Okay to leave voicemail? ❑ yes ❑ no

Other Legal Guardian's (e.g., step-parent's) Name, Address, and Phone: ______________________________
__________________________________________________________________________________________

Names of other adults residing with child: _______________________________________________________

**Emergency Contact:**
Name: ______________________________ Phone: ___________________ Relationship: ________________

Insurance Company: _______________________________________ Phone: _______________________
Name & DOB of PRIMARY Subscriber:_____________________________________DOB: _____________
Employer: _________________________ Group #: __________________________ ID #: ________________
Medicare Secondary Insurance ID#:______________________________ Group#:______________________

**Referral Information** (How were you referred to our practice?)**:**
❑ Professional referral from a clinician or facility (Name: ______________________________________ )
❑ Personal referral from a family member or friend (Name: _____________________________________ )
❑ Internet search (specify): ❑ Google ❑ Yahoo ❑ Facebook ❑ Bing ❑ Other ___________________
❑ I am a previous client returning for services (Previous provider: __________________________________ )
❑ Other (specify): ___________________________________________________________________________

**What are your primary health concerns and/or treatment goals?**

| |
|---|
| **1.** |
| **2.** |
| **3.** |
| **4.** |

**Health care practitioners from whom you are receiving care (physicians, therapists, etc):**

| |
|---|
| **1.** |
| **2.** |
| **3.** |
| **4.** |

**Medical History (complete the following, explaining any "YES" answers below):**

| | YES | NO | | YES | NO | | YES | NO |
|---|---|---|---|---|---|---|---|---|
| Heart Disease | | | Seasonal Allergies | | | Chronic Cough | | |
| Stroke | | | Arthritis | | | Asthma | | |
| High Blood Pressure | | | Osteoporosis/Osteoarthritis | | | Attention Deficit Disorder | | |
| Chest Pain | | | Ulcers | | | Reflux/Heartburn | | |
| Shortness of Breath | | | Constipation | | | Lactose Intolerance | | |
| Irregular Heartbeat | | | Chronic Diarrhea | | | Dizziness | | |
| High Cholesterol | | | Irritable Bowel | | | Fainting | | |
| Swelling of Feet/Hands | | | Colitis | | | Anxiety | | |
| Gallbladder Disease | | | Crohn's Disease | | | Depression | | |
| Diabetes | | | Low Back Pain | | | Disordered Eating | | |
| Kidney Disease | | | Gout | | | Suicide Attempt | | |
| Thyroid Disease | | | Frequent Headaches | | | Self-Mutilation | | |
| Liver Disease | | | Eczema | | | Alcohol Abuse | | |
| Lung Disease | | | Skin Disorders | | | Drug Use | | |
| Cancer | | | Celiac Disease | | | Tobacco Use | | |
| Anemia | | | Fibromyalgia | | | OTHER Illnesses | | |
| Sinusitis/Rhinitis | | | Chronic Fatigue Syndrome | | | | | |

**Please explain any YES answers:**

**List all medications, vitamins, and herbal preparations (prescription & over the counter):**

| |
|---|
| |
| |
| |
| |
| |
| |

## Weight History

| Height: | Current weight: | Desired weight: |
|---|---|---|
| Lowest weight in past year: | Highest weight in past year: | |
| Do you want to lose/gain/maintain weight? | | |
| If applicable, when (and how) did your excess weight gain or weight loss begin? | | |

## Dieting History (list ANY previous weight loss attempts):

| Type | Results | Time on diet |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

## Menstrual Cycle History (if applicable)

Date of your last menstrual cycle:
How frequently do you have a menstrual cycle?:
How long do your cycles last?:

## Choose the best description of your energy level:

- ❑ Usually energetic/occasionally tired
- ❑ Average energy– sometimes more energetic/sometimes more tired
- ❑ Frequently tired/occasionally energetic
- ❑ Always tired/no energy

## Exercise History

| Do you exercise? | If no, why? | |
|---|---|---|
| **Types** | **How often?** | **For how long?** |
| | | |
| | | |
| | | |
| Describe other physical activities: | | |
| What kinds of circumstances interfere with physical activity?: | | |

**Food Choice Inventory:**

| Food dislikes: | Food allergies/intolerances: |
|---|---|
| | |
| | |
| | |
| | |

**Meal Planning:**

| | |
|---|---|
| Who plans meals? | Who cooks? |
| Who shops? | Is a list used? |
| How many people are in your household? | |

**Dining Out:**

How often do you eat out each week? Which meals?

How many times a week do you eat at a fast food restaurant?

**Beverages:**

| | | |
|---|---|---|
| Do you drink alcohol? | Types: | Weekly amount: |
| | | |
| Do you drink coffee/tea? | ❑ Regular ❑ Decaf ❑ Both | Daily amount: |
| Other beverages? | Daily amount: | |

**Food Habits:**

| | |
|---|---|
| Do you skip meals? | If yes, what meals and why? |
| | |
| | |
| Do you crave certain foods? | What?/When? |
| | |
| Do you eat before bedtime? | What? |
| What do you feel are your worst eating habits? | |
| | |
| | |
| What are your food dislikes? | |
| | |
| | |

**Allergy History:**

| |
|---|
| Does anyone in your family have allergies? |
| If yes, who? |
| |
| List all foods, additives, and medications that you know or suspect you are allergic to: |
| |
| |
| |

# Receipt of NPP Acknowledgement and
# Consent to Treatment and Fee Agreement
## Child – Nutrition Counseling

I, the undersigned, acknowledge that I have read or heard the **Notice of Privacy Practices** (NPP). This notice reminds you that during evaluation and treatment at New Directions Counseling Services, LLC, we will be collecting "protected health information" (PHI) about you. We may use or disclose your PHI for treatment, payment, and health care operations purposes with your consent. With your signature below, you are consenting to the use of your PHI for these purposes. If we make changes to our NPP, it will be updated in our waiting room and on our website, or you can get a copy from any staff member. You may revoke this authorization to use or disclose your PHI at any time, but you must do so in writing. If we have already relied on this authorization, we cannot change that, and third party insurers have a right to contest this claim.

I, the undersigned, further acknowledge that I have read or heard the **Treatment and Fee Agreement – Nutrition Counseling** (Agreement), I fully understand the Agreement, and I intend to abide by the Agreement. If I pay for services with third party benefits, I authorize New Directions Counseling Services, LLC to release any and all information necessary to obtain authorization and/or payment for services. I understand that if I am responsible for any part of the payment for services, it is due on the date of service. I acknowledge that I have been given the opportunity to ask questions about the Agreement with a representative of New Directions Counseling Services, LLC. I acknowledge that New Directions Counseling Services, LLC reserves the right to make changes to this Agreement with 30 days' notice.

**I seek and assent to actively participate in nutrition counseling at New Directions Counseling Services, LLC:**

| ______________________________ | ______________________________ | __________ |
|---|---|---|
| **Printed Name of Minor Child** | **Signature of Minor Child (*optional*)** | **Date of Receipt** |

**I consent to my child's participation in nutrition counseling at New Directions Counseling Services, LLC, and I certify that I have legal custody and authority to make decisions regarding the care and treatment of this Minor Child:**

| ______________________________ | ______________________________ | __________ |
|---|---|---|
| **Printed Name of Parent/Legal Guardian** | **Signature of Parent/Legal Guardian** | **Date of Receipt** |
| ______________________________ | ______________________________ | __________ |
| **Printed Name of Parent/Legal Guardian** | **Signature of Parent/Legal Guardian** | **Date of Receipt** |

**Email Consent:**
I consent to receive correspondence from New Directions Counseling Services, LLC by email:

- ❑ NO
- ❑ YES Email Address: ______________________________
  Client name associated with email: ______________________________

**Text Consent:**
I consent to receive correspondence from New Directions Counseling Services, LLC by text:

- ❑ NO
- ❑ YES Mobile Phone Number: ______________________________
  Mobile Phone Service Provider (e.g., Verizon): ______________________________
  (Text reminders are not available for Cricket or Mobile PCS Phones)

# Consent to Communication with Primary Care Provider

Most health insurance companies and managed care organizations request that our office have communication with your Primary Care Physician's (PCP) office for the purposes of coordination of care and of meeting quality assurance standards. This communication typically includes date of first contact, diagnostic information, medications, and treatment recommendations. You have the option of declining to provide your consent for communication between our office and your PCP's office.

If you would like to ***grant consent*** for our office to release information to your PCP's office, please print your name, sign and date below, and please provide your PCP's name and address where indicated:

**Consent granted for:**

| ______________________________ | ______________________________ | ____________ |
|---|---|---|
| **Printed Name of Client** | **Signature of Client/Legal Guardian** | **Date** |

**Name and address of PCP:**

______________________________________________

______________________________________________

______________________________________________

______________________________________________

**Phone and Fax of PCP:** ___________________________________________

If you prefer to ***deny consent*** for our office to release information to your PCP's office, please print your name, sign and date below:

**Consent denied for:**

| ______________________________ | ______________________________ | ____________ |
|---|---|---|
| **Printed Name of Client** | **Signature of Client/Legal Guardian** | **Date** |

# Credit Card Authorization

**PLEASE PRINT INFORMATION CLEARLY:**

**Credit Card Number:** __ __ __ __ __ __ __ __ __ __ __ __ __ __ __ __

**Expiration Date:** **Month** ___ ___ **Year** ___ ___ ___ ___

**CVV Code (back of card):** ___ ___ ___

**Type of Card:** ❑ **Credit** ❑ **Debit** ❑ **Health Savings/Flexible Spending Account**

**Name and Address associated with Card:**

________________________________________

________________________________________

________________________________________

________________________________________

**PLEASE READ THE FOLLOWING INFORMATION CAREFULLY:**

I authorize New Directions Counseling Services, LLC to apply charges to the card listed above under any of the following circumstances:

- At the time of participation in services for the expected amount of an appointment fee to be applied to a health insurance deductible.
- At the time of participation in services for the portion of each appointment fee for which I am responsible including self-pay fees, health insurance copayment amounts and health insurance coinsurance amounts.
- After violation of the practice's cancellation policy requiring payment of a fee for a ***late cancelation or missed appointment*** per the practice's Consent to Treatment and Fee Agreement.

I am aware that New Directions Counseling Services, LLC will be unable to notify me before processing this card on file and that my card may be charged at any time at the discretion of New Directions Counseling Services, LLC for the reasons listed above.

| ______________________ | ______________________ | __________ |
| --- | --- | --- |
| **Printed Name of Client** | **Signature of Client/Legal Guardian** | **Date** |

# Treatment and Fee Agreement - Nutrition Counseling

**PLEASE REVIEW THIS INFORMATION CAREFULLY AND TAKE IT WITH YOU FOR FUTURE REFERENCE.**

At New Directions Counseling Services, LLC (NDCS) our aim is to nurture transformation and foster sustainable well-being for individuals and families. We are a heart-centered practice dedicated to helping our clients create positive, life-altering changes through traditional and alternative health care solutions. Our team is focused on building connections and providing personalized care for each client.

**General Information about Nutrition Appointments:**

Initial evaluations for nutrition counseling will be 75 to 90 minutes in length. Follow-up nutrition appointments will be 45 to 60 minutes in length. Please make every effort to arrive on time for your appointments, as we are not able to extend appointments due to late arrivals. We will also make every effort to begin your appointments at their designated times, and if a dietitian begins an appointment late you will get the benefit of the full treatment time.

If you need to cancel a scheduled appointment, you are required to provide us with 24 hours advance notice. ***You will be <u>charged $75</u> for any nutrition appointments that are canceled without such notice or completely missed without any notice.*** Such late cancellation or missed session fees cannot be reimbursed to any extent through third party benefits, and you will be responsible for this fee. We do not charge for late cancellations that are due to truly urgent or emergency situations, including an unexpected illness.

**Financial Arrangements for Nutrition Services:**

If you have a health insurance policy or some other type of third party benefits that you would like to utilize to pay for services, you must notify us prior to or at your initial appointment. Please be aware that if you use a third party to pay for services, we must provide some of your protected health information to the payor to process claims for services rendered. Our office will verify your benefits and submit claims directly to your benefits carrier. ***Please be aware that you assume ultimate responsibility for knowing the specific coverage provided by your benefits, including coverage limitations, and service authorization requirements.*** Patients maintain financial responsibility for any claims denied by their third party benefits carrier and for any checks sent directly to a patient by their third party benefits carrier.

***If you accumulate a balance of more than $100, you will be required to make payment to reduce your account balance before you can schedule additional appointments at our practice.***

***Any account with an outstanding balance more than 90 days past due, without a payment arrangement approved by our office, will be sent to a Collections Agency. In these situations, you (the client) agree to reimburse New Directions Counseling Services, LLC for the amount of the fees of any Collections Agency (initially 33% of the total debt and over time up to 50% of the debt), and all costs and expenses (including reasonable attorneys' fees) that New Directions Counseling Services, LLC incurs in such collection efforts.***

Finally, there is a $25.00 charge for any checks returned to our office by a financial institution due to insufficient funds.

***We require a valid credit card on file*** at all times while you are receiving Nutrition Services at our practice. There is a Credit Card Authorization form included with this packet for you to complete. We will charge your credit card at the following times:

- When you are using third party benefits to pay for our services and you have a deductible, we will charge your credit card *after each visit at our practice* for your benefits carrier's contracted rate that we anticipate will be applied to your deductible.
    - Please note that a refund will be issued to your credit card if the charges we have applied exceed the amount of your health insurance deductible.
- At each appointment if you are self-pay.
- At each appointment for any copayment or coinsurance amounts due.
- Any time you have outstanding copayment or co-insurance payment amounts due for Nutrition Services.
- After violation of the practice's cancellation policy for the fee associated with a ***late cancelation or missed appointment***.

**Confidentiality of Nutrition Services:**

In order to protect your confidentiality, we adhere to the following procedures:

1. Inquiries about you made in person, in writing, or by telephone will not be acknowledged by any of our staff members without your authorization. You must sign our Authorization to Release Information form before any information about you will be given to any party outside New Directions Counseling Services, LLC, unless it meets the exception criteria outlined below in sections two and three.
2. Pennsylvania state law requires exceptions to confidentiality including but not limited to:
    a. If you express a serious threat or intent to kill or seriously injure yourself or an identifiable person or persons.
    b. If we have reasonable cause to suspect abuse or neglect of a child or vulnerable adult.
    c. When we are required to do so by legal order of a court.
3. New Directions Counseling Services, LLC is a group practice and providers at the practice share administrative resources. This means that other providers at the practice may have indirect access to your information (e.g., your name). On occasion, your provider may also engage in collaboration or consultation with other providers at the practice with the aim of providing the highest quality treatment to you. Further, your clinical record may be utilized by more than one treatment provider in the event that you are receiving treatment with our therapeutic and/or psychiatric practitioners. Our administrative staff members also have access to your information strictly for administrative purposes. All clinical and administrative staff members adhere to our Privacy Practices.

Regarding sections two and three above, providers will, whenever possible, inform you of their intent to share information with a third party. If you express thoughts about harming yourself or someone else, every effort will be made to resolve the issue through treatment before information is released to an outside party.

**Emergencies:**

If you need to contact us regarding an urgent matter, please try reaching your dietitian at the office telephone number, 724-934-3905. If your dietitian is not available at the office, a secondary, emergency telephone number is provided on the office voicemail. If you are having an emergency and you are not able to contact your dietitian, you should immediately proceed to the emergency room of the medical facility that is nearest to you at the time of the emergency.

# Notice of Privacy Practices - Abbreviated*

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

**Uses and Disclosures for Treatment, Payment, and Health Care Operations**
We may **use** or **disclose** your **protected health information (PHI)**, for **treatment**, **payment**, and **health care operations** with your consent. **PHI** refers to identifying information in your health record. **Treatment** is when we provide or manage your health care. **Payment** is when we obtain reimbursement for your healthcare. **Health care operations** relate to the performance and daily routines of the practice. **Use** applies to activities within the practice. **Disclosure** applies to activities outside of the practice.

**Uses and Disclosures Requiring Additional Authorization**
We may also use or disclose your PHI for purposes outside of treatment, payment, and health care operations, however, you must sign a separate Authorization to Release Information form to allow this. You may revoke any authorizations of PHI at any time, but you must do so in writing. You may not revoke an authorization to the extent that we have already relied on the authorization and third party insurers have a right to contest this claim.

**Uses and Disclosures with Neither Consent nor Authorization**
We may use or disclose your PHI without your consent or authorization in the following circumstances. There may be additional disclosures of PHI that we are required or permitted by law to make without your consent, but the ones listed below are the most common.

- If you express a serious threat to kill or injure yourself or an identifiable person or persons, we must notify the potential victim or victims and others (such as law enforcement personnel) to keep you or others safe.
- If we have reasonable cause to suspect abuse of a child or vulnerable adult.
- When we are required to do so by legal order of a court.
- For worker's compensation, disability, and other similar programs.

**Client's Rights**

- You have the **right to request restrictions** on certain uses and disclosures of your PHI.
- You have the **right to receive confidential communications by alternative means and at alternative locations**. For example, you could ask us to send your bill to a different address or call you only at home and not at work.
- You have the **right to review** your PHI. There may be a charge if copies are requested.
- You have the **right to amend** your PHI by written request if you believe your record is incorrect.
- You have the **right to notification** if there is a privacy breach of your PHI.
- You have the **right to an accounting** of disclosures of your PHI.
- You have the **right to a paper copy** of this notice.
- You have the **right to file a complaint** if you feel your privacy rights have been violated. Complaints must be in writing and sent to our compliance officer (listed below). You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services. We will not retaliate against you for exercising this right.

**Health Care Provider's Duties**

- We are required by law to maintain the privacy of your PHI and to notify you of our legal duties and privacy practices regarding your PHI.
- We are required to abide by the terms of this notice, although we have the right to change the privacy policies and practices described here as long as we provide proper notification.
- We are required to provide proper notification if we revise the policies and procedures listed here.

If you have any questions or concerns related to this notice or additional rights which may be granted to you by the laws of Pennsylvania, please contact our compliance officer, Dr. Michael Schneider, by phone at 724-934-3905x31 or by email at mschneider@newdirectionspgh.com.

***This abbreviated version provides the basic information about your privacy rights and what we do to protect your privacy rights. A longer, more detailed version is available in our waiting room, on our website, or from any staff member.**