Information

Office: 703-552-2722
Fax: 703-564-8567
E-mail: info@washnutrition.com

Name *

Middle Name

Preferred Name

Sex ☐ Male ☐ Female

Age

Birth Date

Address/Apt #

City/State/Zip

Primary Phone/Email

Marital Status ☐ Married ☐ Divorced ☐ Widow ☐ Single ☐ Legally Separated

Social Security #

Primary Phone/Email Address

Have you ever been a patient of our practice Yes No

Employment Status ☐ Full Time ☐ Part Time ☐ Retired ☐ Full Time Student ☐ Part Time Student

Reason for Visit

Referred By ☐ Website ☐ Google ☐ Social Media ☐ Walk In ☐ Friend ☐ Family

Referral

Insurance

Who is responsible? ☐ Self ☐ Spouse ☐ Father ☐ Mother ☐ Other ☐ Family

Name

Age

Birth Date

Sex — Male / Female

Address/Apt #

City/State/ZIP Code

Social Security #

Primary Phone/Email Address

Primary Insurance

Do you have Insurance? — Yes / No

Insurance Company Name

Insurance ID #

Insured First and Last Name

Insurance Phone

Group Name/Number

Relation to Patient

Birth Date

Sex — Male / Female

SSN/Contact Phone

Address/Apt #

City/State/ZIP Code

Secondary Insurance

Do you have Secondary Insurance? — Yes / No

Secondary Insurance Company Name

Insurance ID #

Insured First and Last Name

Insurance Phone

Group Name/Number

Relation to Patient

Birth Date

Sex — Male / Female

SSN/Contact Phone

Address/Apt #

City/State/ZIP Code

Health History

Name of Current Physician

Phone

Date of Last Visit

Have You Had:

Condition			Condition			Condition		
ADD/ADHD	Yes	No	Chronic Fatigue Syndrome	Yes	No	Gout	Yes	No
Radiation Treatment	Yes	No	Headaches	Yes	No	Circulatory Problems	Yes	No
AIDS/HIV Positive	Yes	No	Rapid Weight Gain/loss	Yes	No	Alcoholism	Yes	No
Heart Attack	Yes	No	Heart Disease	Yes	No	Allergies/Hayfever	Yes	No
Convulsions/ Seizures	Yes	No	Anemia	Yes	No	Heart Surgery	Yes	No
Herpes	Yes	No	Sleep Apnea	Yes	No	Smoking	Yes	No
High Blood Pressure	Yes	No	Crohn’s Disease	Yes	No	Depression	Yes	No
Snoring	Yes	No	Anxiety	Yes	No	Stroke	Yes	No
High Cholesterol	Yes	No	Irritable Bowel Syndrome	Yes	No	Diabetes	Yes	No
Dizziness/fainting	Yes	No	Drug Addiction	Yes	No	Kidney Disease	Yes	No
Thyroid Disease	Yes	No	Liver Disease	Yes	No	Bipolar Disorder	Yes	No
Fen-Fen Use	Yes	No	Bruises Easily	Yes	No	Cancer	Yes	No
Fever Blisters	Yes	No	Cerebral Palsy	Yes	No	Chemotherapy	Yes	No
Gall Bladder Problems	Yes	No	Ulcerative Colitis	Yes	No	Osteoporosis	Yes	No

Psychiatric Care Yes No

Any Drug Or Food Allergies? Yes No

Any Other Medical Conditions Not Listed Above?

Are You Currently Under A Physician’s Care? Yes No

If Yes, Describe

Are You Being Treated For Cancer Of Any Kind? Yes No

May I Have Your Permission To Speak Directly With Your Physician(s) Regarding Your Treatment? Yes No

Have You Ever Been Hospitalized? Yes No

If Yes, Describe

Women: Are You Pregnant? Yes No

Nursing? Yes No

Taking Birth Control Pills? Yes No

If Yes, Please Indicate The Condition Being Treated.

Have You Ever Experienced An Adverse Reaction During Medical Treatment? Yes No

List All Medications You Are Now Taking (Please Include Over-the-counter Vitamins, Herbs, Pain Relievers And Illegal Drugs)

I have reviewed the information on this questionnaire and it is accurate to the best of my knowledge. I understand that this information will be used by Washington Nutrition Group to help determine appropriate and healthful treatment. If there is any change in my medical status, I will inform Washington Nutrition Group. I authorize the insurance company indicated on this form to pay Washington Nutrition Group all insurance benefits otherwise payable to me for services rendered. I authorize the use of this signature on all insurance submissions. I authorize Washington Nutrition Group to release all information necessary to secure the payment of benefits. I understand that I am financially responsible for all charges whether or not paid by insurance.

Signature Of Responsible Party

Date

Payment is due in full at time of treatment, unless prior arrangements have been approved health history.

Authorization

Release Of Information

Employees of this office must have your permission to relay your medical information to someone you authorize us to communicate with via phone/text/email. If you do not give us permission to speak to a specific person on your behalf, we will be unable to relay any information to anyone other than the you the patient or parent/legal guardian.

Please list below anyone you authorize our office to discuss your medical care and test results with, we will keep this authorization on file and it will remain in effect until you revoke authorization by written notice.

Person 1

Person 2

Person 3

Financial Agreement

We ask that you realize that we don't work for an insurance company. Rather we work 100% for our patients. We feel that insurance can be a great benefit for many patients and want you to know we will do everything in our power to ensure you get every benefit allotted in your insurance contract. However, the treatment we recommend and the fees we charge will always be based on your individual needs, not your insurance coverage.

Signature of Patient

Date

Insurance and Payment Policies

Your insurance is a contract between you, your employer, and the insurance company. We are not a party to that contract. As a courtesy, we will file your initial claim for you at no charge. If you have a co-pay or deductible we require your estimated portions be paid at the time of service. We will then gladly file insurance claims as a courtesy to you, but any and all account balances are ultimately your responsibility. Please note that not all services are a covered benefit in all contracts.

At the time of scheduling your visit we require you give us your credit card information. We store your credit card number in a secure reputable payment processor called STRIPE.

We will charge your credit card for any outstanding balances unpaid after 30 days of you receiving a bill for the unpaid services. We will also charge your credit card for no show fees on the same day of the missed appointment. Please keep in mind that we are a small business and failing to call and cancel your appointment without a 24-hour advance notice can have severe effects on our practice. If you must change or miss an appointment, we require a 24-hour advance notice. Cancellations, last minute rescheduling or failure to show will result in a broken appointment charge of $50 per nutrition appointment and $100 per therapy appointment. This policy is strictly enforced. As a courtesy, our office will provide confirmation calls and reminder cards to you. If your credit card does not go through we will send you a final bill with a collections letter. If the balance is not paid within two weeks of receipt of the collection notification letter, your information and amount due will be turned over to collections.

Should your insurance coverage change, we do require this change at your appointment in order to utilize your new benefits for the scheduled appointment. If we do not receive this change within 48 hours of your appointment you will be responsible for all charges.

Should you have a credit on your account after your insurance company pays their portion, it is your responsibility to call and request the credit be refunded to you.

The parent who requests treatment for a child is responsible to us for all fees incurred.

CONSENT I have read and understand all the above information. The undersigned hereby give authorization to perform those diagnostic and treatment procedures deemed necessary. If I ever have any change in my health or change in my medication, I will inform the doctor at the next appointment. For insured patients, my signature below authorizes assignment of insurance benefits to the doctor and authorizes the release of medical records to my insurance company.

Signature of Patient

Date

HIPAA Authorization

The Health Insurance Portability and Accountability Act (HIPAA) provides safeguards to protect your privacy. Implementation of HIPAA requirements officially began on April 14, 2003. Many of the policies have been our practice for years. This form is a “friendly” version. A more complete text is posted in the office.What this is all about: Specifically, there are rules and restrictions on who may see or be notified of your Protected Health Information (PHI). These restrictions do not include the normal interchange of information necessary to provide you with office services. HIPAA provides certain rights and protections to you as the patient. We balance these needs with our goal of providing you with quality professional service and care. Additional information is available from the U.S. Department of Health and Human Services. www.hhs.govWe have adopted the following policies:1. Patient information will be kept confidential except as is necessary to provide services or to ensure that all administrative matters related to your care are handled appropriately. This specifically includes the sharing of information with other healthcare providers, laboratories, health insurance payers as is necessary and appropriate for your care. Patient files may be stored in open file racks and will not contain any coding which identifies a patient’s condition or information which is not already a matter of public record. The normal course of providing care means that such records may be left, at least temporarily, in administrative areas such as the front office, examination room, etc. Those records will not be available to persons other than office staff . You agree to the normal procedures utilized within the office for the handling of charts, patient records, PHI and other documents or information.2. It is the policy of this office to remind patients of their appointments. We may do this by telephone, e-mail, U.S mail, or by any means convenient for the practice and/or as requested by you. We may send you other communications informing you of changes to office policy and new technology that you might find valuable or informative.3. The practice utilizes a number of vendors in the conduct of business. These vendors may have access to PHI but must agree to abide by the confidentiality rules of HIPAA.4. You understand and agree to inspections of the office and review of documents which may include PHI by government agencies or insurance payers in normal performance of their duties.5. You agree to bring any concerns or complaints regarding privacy to the attention of the office manger or the doctor.6. Your confidential information will not be used for the purposes of marketing or advertising of products, goods or services.7. We agree to provide patients with access to their records in accordance with state and federal laws.8. We may change, add, delete or modify any of these provisions to better serve the needs of the both the practice and the patient.9. You have the right to request restrictions in the use of your protected health information and to request change in certain policies used within the office concerning your PHI. However, we are not obligated to alter internal policies to conform to your request.The attached notice describes how medical/dental information about you may be used and disclosed and how you can get access to this information. Please read it carefully.

Signature of Patient

Date