For Office Use Only:

Location:
Practitioner:
Date of Service:
Number of Units:
Dx. Codes:

NUTRITION IN MOTION, LLC
STAY IN MOTION, LLC
Client Intake Form

80 Palomino Lane, Suite 101, Bedford, NH, 03110

Phone: 603-518-5859 www.nimnh.com

Please e-mail or fax this form AND a copy of your Insurance Card to:

(603) 606-1032 or 80palomino@gmail.com

PATIENT INFORMATION:	Patient	Spouse/Partner/Parent (if applicable)
First and Last Name:		
Street Address:		
City, State		
Zip Code:		
Home Phone:	OK to leave message: Y N	
Work Phone:	OK to leave message: Y N	
Cell Phone:	OK to leave message: Y N	
E-Mail Address:		
Date of Birth:		
Social Security Number:	(last four digits) XXX-XX-	
Marital Status:	Single Married/Partnered Divorced Widowed	Single Married/Partnered Divorced Widowed
Employment Status	Not Employed Full Time Part Time	Not Employed Full Time Part Time
Student Status:	Non Student Full Time Part Time	Non Student Full Time Part Time
Racial Background	Caucasian Hispanic Black Asian Indian	Caucasian Hispanic Black Asian Indian
Gender:	Male Female	Male Female
PRIMARY CARE DOCTOR:	**PCP Name:**	
	PCP Location:	
Would you like to receive our Wellness Newsletter?		Yes No

INSURANCE INFORMATION:	PRIMARY INSURANCE:	SECONDARY INSURANCE:
Patient Rel. to Policy Holder:	Self Spouse Child Other	Self Spouse Child Other
Employer:		
Insurance Company:		
Patient's Policy Number:		
Policy Group Number:		

AUTHORIZATION:

Nutrition In Motion (NIM) and Stay In Motion (SIM) are dedicated to maintaining the privacy of your individually identifiable health information. In conducting business, NIM/SIM will create records regarding you and the treatment and services provided to you. NIM and SIM will maintain your information in a Confidential manner. I recognize that the information will be used or disclosed for the purpose of assessment and treatment of my health. This purpose is provided so that I can make an informed decision whether to allow release of the information.

This authorization will expire one year after the date of this authorization.

I HEREBY AUTHORIZE MY INSURANCE COMPANY BENEFITS TO BE PAID DIRECTLY TO THE PROVIDER. I REALIZE I AM RESPONSIBLE TO PAY FOR ANY NON-COVERED SERVICES. I HEREBY AUTHORIZE THE RELEASE OF PERTINENT MEDICAL INFORMATION TO MY PROVIDERS AND THE INSURANCE COMPANY.

______________________________ _______________

Signature or Legal Representative's Signature Date

Please attach a Copy of your Insurance Card

NUTRITION
IN MOTION

Patient Questionnaire

Patient Name:________________________________ **Patient Date of Birth:** _______________

What information would you like to gain from your one-on-one session?

Weight Management	Meal Planning	Eating for optimal performance
Eating Out	Food Labels	Vitamin & Mineral Supplements
Exercise	Disease Prevention	Healthy Food Preparation
Supermarket Shopping	Portion Sizes	Stress Management

Height __________ Weight (lbs.) _______________ Years at current weight _______________

Maximum adult weight (lbs) _________________ when was this? __________________________

Is your spouse/partner overweight? No Yes Not Applicable

Have you tried to lose weight in the past? No Yes If yes, please describe methods tried

____

Do you follow a special dietary plan, such as low cholesterol, low carbohydrate or vegetarian?
No Yes, if yes, please explain: ____

Are there certain foods that you do not eat?

____

Who usually cooks? Self Family member Shared responsibility

Who usually shops for groceries? Self Family member Shared responsibility

How often do you eat out?
Multiple times per day Daily Weekly Monthly Less than monthly

What restaurants do you frequent? ____

How often do you eat fast food?
Multiple times per day Daily Weekly Monthly Less than monthly

Please check all the reasons you eat:

Hunger	Habit	Lonely	Anxious	Bored
Angry	Happy	Tired	Stressed	Frustrated

Do you smoke? No Yes If yes, how much__________how many years ___________

NUTRITION IN MOTION

Patient Questionnaire

Do you consume alcohol? No Yes If yes, approximately how many per week ___________

Current Physical Activity Level (circle one): low moderate heavy

Describe your typical activity during the week:

____

Do you currently have any physical activity limitations? No Yes If yes, please explain:

Are you taking any medications? No Yes If yes, please list:

____

Are you taking any vitamins or supplements? If yes, list:

____

Please check all that apply to you or a family member:

Category	Symptom/Sign/Condition	You	Family History
Constitutional	Decrease in Appetite		N/A
	Fatigue		N/A
	Weight gain		N/A
	Weight loss		N/A
Cardiovascular	High blood pressure		
	High cholesterol		
	High triglycerides		
	Heart attack		
	Chronic heart disease		
	Other cardiovascular issue		
Endocrine	Diabetes Type 1		
	Diabetes Type 2		
	Hypo/Hyperthyroidism		
	Other endocrine issues		
Gastrointestinal Hx	Celiac disease		
	Crohn's disease		
	Gallstones		
	GERD/Reflux		N/A
	Irritable Bowel Syndrome		
	Other		

NUTRITION IN MOTION

Patient Questionnaire

Category	Symptom/Sign/Condition	You	Family History
Gastrointestinal	Abdominal pain		N/A
	Constipation		N/A
	Diarrhea		N/A
	Dumping syndrome		N/A
	Excess gas		N/A
	Heartburn		N/A
	Nausea		N/A
	Vomiting		N/A
	Other GI issue		N/A
H/L/I	AIDS		N/A
	Anemia		N/A
	HIV		N/A
	Other blood disorders		N/A
Musculoskeletal	Arthritis		N/A
	Fibromyalgia		N/A
	Gout		N/A
	Osteopenia/Osteoporosis		N/A
	Other musculoskeletal issue		N/A
Neurological	Stroke		
	Migraines		
	Seizure disorder		N/A
	Other neurological issues		
Other	Alcoholism		
	Anxiety		N/A
	Cancer		
	COPD		
	Depression		
	Eating disorder		
	Sleep apnea		N/A

Have you had any other medical issues not listed above? If so, please state:

____

Office Policies

Thank you for choosing Nutrition In Motion, LLC as your care provider. Because some of our patients have had questions regarding patient, clinician and insurance responsibility for services rendered, we have developed this policy. Please read it, ask us any questions you may have, and sign in the space provided. A copy will be provided to you upon request.

1. Privacy Practices. We care about your privacy. The information we collect about you is private. Only people who have the need **and** legal right may see your information. Unless you give us permission in writing, we will only disclose your protected health information (PHI) for the purposes of treatment, payment, healthcare operations and when we are required by law to do so. Please review our Health Insurance Portability and Accountability Act (HIPPA) Notice of Privacy Practices.

2. Insurance. We participate in most insurance plans. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

3. Co-payments and deductibles. All co-payments and deductibles must be paid at the time of service. This arrangement is part of our contract with your insurance company. Failure on our part to collect co-payments and deductibles from patients can be considered fraud. Please help us in upholding the law by paying your co-payment at each visit.

4. Non-covered services. Please be aware that some – and perhaps all – of the services you receive may be noncovered or not considered reasonable or necessary by your insurer. Some Insurance companies may require precertification or authorization for services rendered. It is **your** responsibility to acquire the appropriate approvals before your office visit. In the event that your Insurance carrier denies coverage or benefits for either of these reasons, you will be responsible for payment of the visit.

5. Proof of insurance. All patients must complete our Patient Intake form before seeing the clinician. We must obtain a copy of your current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. If your insurance changes, please notify us before your next visit so we can make the appropriate changes to help you receive your maximum benefits.

6. Missed appointments. Our policy is to charge for missed appointments not canceled within a reasonable amount of time. These charges will be your responsibility and billed directly to you. Please help us to serve you better by keeping your regularly scheduled appointment.

7. Billing Authorization. I authorize the Clinicians at Nutrition In Motion, LLC to release all information required to process my insurance claims using the HCFA 1500 form. I authorize my insurance company to make payments directly to Nutrition In Motion, LLC.

Our practice is committed to providing the best treatment to our patients. Please let us know if you have any questions or concerns.

I have read and understand the office policies and agree to abide by its guidelines.
I acknowledge that I have reviewed Nutrition In Motion's Notice of Privacy Practices.

____ ____________________
Print Name **Date of Birth**

____ ____________________
Signature of Patient or Responsible Party **Date**

NOTICE OF PRIVACY PRACTICES

This notice describes how our staff will handle and disclose your private medical information. Please review it carefully.

We believe that all medical information is personal and we are committed to protecting it. A record of all care and services you receive from our office and staff is maintained to insure that you receive the highest quality of care possible. This record is also necessary for us to comply with certain legal requirements.

We are legally required to:

- Keep your medical information private
- Provide you with this form explaining our privacy policies and procedures
- Adhere to the current listed policies and procedures

We have the right to:

- Change our privacy policies and procedures, compliant with legal requirements at any time.
- Make any changes to our policies and procedures effective for all medical information that we keep including information already on file

We will not use or disclose your medical information for any purpose not listed below without your specific authorization.

Treatment – Medical information about you may be disclosed to other healthcare providers to assist them in treating you.

Payment – Your medical information may appear on documents accompanying bills sent to you or a third party payer.

Signed: ___________________________________Date: ________________