**Office Policies and Registration Instructions. In order to meet your needs and provide you the best possible care, we ask you to honor the following guidelines.**

**Fees.** Our charges are simple, it is for our time in increments of 15 minute units, the fee per 15 minute unit is based on a contracted rate if you are covered by insurance and if our office is a provider for your plan, otherwise we charge a set $45/15minute unit. A minimum initial visit is 60 minutes or 4 units. Follow-up office visits are based on the frequency you attend and complexity of your needs: 30-90 minutes.

**Download and Complete Our Office Registration Forms. Down load forms:**

**1) Registration Form.** All new patients or patients returning after one year, must complete the registration form including the signature of the party responsible for payment.

**2) MD Referral Form.** If you have a medical condition or are under or overweight, you must have your doctor (MD) complete the MD Referral Form and have it faxed by your MD to us prior to your first visit. This form is available for you to download and give to your doctor before you come to my office. This is different than the referral or authorization form that maybe required by your insurance company. Referral forms must include your diagnosis AND the doctor’s full name.

**3) Food Record.** Complete the downloadable food record including the time and date you ate, the amount and type of food and the location you ate: K=kitchen, R=restaurant, W=work, S=school

**Important Insurance Details.**

If you have insurance and we are listed as a provider for your plan, it does not guarantee coverage. It is important to verify your coverage before you attend the first office visit. Using the downloadable registration form, answer the questions pertaining to your coverage. Also refer to our commonly asked insurance questions**.**

**Insurance Referral or Authorization.** If we are a provider, and your plan covers for nutrition counseling and your insurance requires a referral from your MD to us, please be sure this is done prior to your visit. This form is generated by your primary care physician (PCP). We will usually receive an electronic authorization of approval once this is done by your PCP. It is important this be done before the first visit.

**Lastly, answer all questions on the down loadable Registration Form and other forms, sign them and bring the originals to your first visit even if you sent them prior. If we are not a provider for your plan that does not mean you will not get reimbursement. Some plans will pay you directly once you submit a bill to them.**

**No Insurance Coverage?** You must pay 100% of services rendered at the time of the visit if we do not accept your insurance. You may pay via cash, credit card(Visa or Mater Card) or checks made payable to Life Focus Nutrition LLC. Please record the date and time of your appointment. In some situations a pre-arranged sliding scale is available.

**Thank You for selecting our services!**

**Thank you** for choosing Life Focus Nutrition LLC. In order to provide you and your family with the best possible care, we would like to help you prepare for your first visit with us. Please read our office policies, instructions below and then sign then bottom.

**Please bring the following items with you:**

° 1-3 day diary of all food and beverages consumed each day

° Photo ID

° Insurance Card (if visit is covered by your insurance)

° Insurance Authorization (based on our conversation, per your insurance)

° Co-pay – **MUST** be Cash, if co-pay is under $35. For other payments make checks payable to **Life Focus Nutrition LLC**  or Visa or Master Card will be accepted.

**If you or** your child is underweight or may have an eating disorder please follow these instructions:

° No beverages or fluids should be consumed one hour prior to the visit

° Nothing to eat half hour prior to visit

**Our Appointment Policy:**

We know your time is valuable and we pride ourselves on keeping wait times to a minimum. Please help us maintain this standard by arriving 10 minutes early to fill out any necessary paperwork, as your appointment will start promptly at your scheduled time. Sometimes our patients are late due to traffic, etc. **If you are late your appointment may need to be rescheduled with a cancellation fee imposed**. Our priority to allow sufficient time to address individual needs so please plan ahead to avoid this. For your convenience, we have included the Patient Registration Form on our website. Please feel free to call us if you have any questions or if we can do anything to further assist you. *After your first visit we will customarily ask you to schedule 3-6 visits depending on your needs. The visits assist you in making progress in lifestyle habits and lapse in time between visits often delays progress especially for children. So be committed to helping to maintain the appointments set. This is a small investment and a gift for a life time!*

**Cancellation Policy:**

Once you have made your appointment, we also ask that you please give us **24 hours’ notice to cancel** or reschedule to avoid a fee. This fee is waived if you call due to inclement weather or sudden medical emergency. Cancellation can be made by calling (914)935-0123 or (203)321-8454. Do NOT text or email cancellations please. **$50.00 fee will be charged if you cancel with less than 24 hour notice.**

Thank you and we look forward to working with you to help you achieve all of your health and nutrition goals! Sincerely, Linda Arpino, MA,RD,CDN

**I have read and agree to the terms listed above.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Print Name**

#### Patient over 17 or Guardian Signature Date

**PATIENT INFORMATION**

***Please attach a photo identification card (drivers’ license) and insurance card.***

***Please sign page 1,3, & 6. Optional: Scan and Email this form to*** [***la@lifefocusnutrition.com***](mailto:la@lifefocusnutrition.com)***. Put “new patient” in subject line OR Fax to (866)293-4500 before your visit. Please bring the original copy to your first visit.*** ***Thank you and look forward to working with you! Linda Arpino, RDN,CDN***

Last Name\_ First Name Initial

Date of Birth

Street Address

City \_\_\_\_\_State ZIP\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age

Sex M F

Phone Number: Day ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Evening ( )

Cell phone ( \_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_

E-mail \_\_\_\_

Marital Status: Married \_\_\_\_\_\_ Single \_\_\_\_\_\_Divorced \_\_\_\_\_\_Widow

If child, custodial Parent(s)/Guardian

Mother: Father:\_\_\_\_\_\_\_ \_\_\_\_\_\_

Tel.# if different: Home ( ) ( )

Cell ( ) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address if different:\_ \_\_\_\_\_\_

**PAYMENT INFORMATION/ PRIMARY INSURANCE**

Name of Primary Holder of Insurance Policy \_\_\_\_\_\_

Relationship to Patient Birth date \_\_\_\_\_\_\_\_ \_\_\_\_

Address Home Phone( ) \_\_\_\_\_\_

City State Zip

Responsible Party Employed By Business Phone ( ) \_\_\_\_\_\_\_\_\_

Business Address Occupation \_\_\_\_\_\_

Insurance Company \_\_\_\_\_

Insurance Company Address \_\_\_\_\_\_

Subscriber I.D. # Group \_\_\_\_\_\_

Person Responsible for payment if different than above \_\_\_\_\_\_\_

Relationship \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address if different Phone Number

**OPTIONAL: MUST BE OVER 18 years old**

I AUTHORIZE EMAILS TO BE SENT TO ME BY LIFE FOCUS NUTRITION LLC and Linda Arpino

Email address of legal guardian/guarantor:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I AUTHORIZE TEXTING TO BE SENT TO CORRESPOND TO ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### PATIENT HIPAA AWARENESS

With my permission, Life Focus Nutrition LLC (to be referred to as LFN LLC) may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to LFN LLC notice of Privacy Practices for a more complete description of such uses and disclosures on the office registration clip board or at lifefocusnutrition.com.

PHI=Primary Health Insurance TPO= For Treatment, Payment and Healthcare Operations

I have the right to review the Notice of Privacy Practices prior to signing this consent. LFN LLC reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to LFN LLC. With my permission, the office of LFN LLC may email or call my home or other designated locations and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my permission, the office of LFN LLC may mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements as long as they are marked Personal and Confidential. I have the right to request that LAA, Inc. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. By signing this, I am allowing LFN LLC to use and disclose my PHI for TPO.

I understand referrals are due before the day of the consult. If there is no referral, if LFN LLC is not in my health insurance network or if my policy does not include nutrition services, I am ultimately responsible for payment. Our fee is $40 per 15-minute unit. Most visits vary from 45-90 minutes. I understand a cancellation fee of $50.00 will be charged if I do not cancel a scheduled appointment 24 hours before my appointment.

**ASSIGHMENT AND RELEASE OF PAYMENT**

I hereby authorize payment directly to LFN LLC for all insurance benefits otherwise payable to me for services rendered. I understand that I am financially responsible for all changes AT THE TIME OF THE VISIT, whether or not paid by insurance, and for all services rendered on my behalf or my dependents. I will be charged a $35 banking fee for all checks that do not clear and 5% interested added and compounded monthly on all bills that are not paid after at the visit or upon receipt of a bill. I will be responsible for all costs associated outstanding debt including collections services.

I authorize the above and/or any provider or supplier of services in this office to release any information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Below are health care professionals I would like a progress report sent to and I give permission to share my health treatment plan, including pertinent test results.

We like to communicate with your health care providers. Please list them below :

**PRIMARY PHYSICIANS NAME**:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Telephone #(\_\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_

Town:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Zip\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**List Other Health Care Professionals** and Office Location Below:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EXERCISE WAIVER**

I am aware that engaging in physical exercise and exercise equipment, facilities, training and instruction could cause injury to me. I am voluntarily participating in these activities and assume all risks of injury that might result. I agree to waive any claims or rights I might otherwise have to sue the owners, officers, employees, or agents of LIFE FOCUS NUTRITION LLC for injury as a result of these activities.I have carefully read this waiver and have been advised to consult my physician before undertaking a physical exercise program. I am aware that it is my responsibility to consult my physician regarding exercise.

**I have read and answered all information accurately and below is my authorizing signature for treatment and**

**payment of services rendered.**

**Print Patient Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Print Guarantor/legal guardian** if different then above:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date**   **Patient/Guarantor Signature** (older than 17 years old or Parent or Legal Guardian)

**COMPLETE PRIOR TO YOUR VISIT OR AT OUR OFFICE**

**ASSESSMENT SECTION.** Please complete the following assessment as thoroughly as possible. The information provided helps us to get to know you and customize a plan to meet your specific health and lifestyle needs.

#### NUTRITION PROFILE: Main Nutritional Concerns:

Weight management

Eating disorders (anorexia, bulimia,

Cardiovascular risk management binge/compulsive eating disorder)

Increase energy and reducing fatigue

Children & adolescent nutrition

Menopause

Family nutrition

Diabetes management

Nutrition & aging

Sports nutrition

Other (please describe)

#### MEDICAL HISTORY

Have you or any members of your immediate family ever been treated for: YOU Biologic FAMILY YOU Biologic FAMILY

\_\_\_\_ \_\_\_\_ Alcoholism

\_\_\_\_ \_\_\_\_\_ Arthritis \_\_\_\_ \_\_\_\_ \_\_\_\_ Cancer \_\_\_\_

Cataracts/ Eye \_\_\_\_

Chronic Fatigue \_\_\_\_\_

\_\_\_\_\_ Depression

\_\_\_\_ Diabetes \_\_\_\_\_

Gastric reflux

\_\_\_\_\_\_ Eating Disorder(Anorexia)

\_\_\_\_\_ \_\_\_\_\_ Bulimia Other

\_\_\_\_ \_\_\_\_ Heart Disease

\_\_\_\_\_ Hypoglycemia

\_\_\_\_ High Blood Pressure

High Cholesterol

High Triglycerides

Liver Disease

Obesity

\_\_\_\_\_ Substance Abuse

Stroke

Thyroid Hypo/Hyper

**LIST CURRRENT MEDICAL CONDITIONS** you are treated for

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**HOSPITALIZATIONS:** Reason Date

**List all MEDICATIONS your take currently or attach a list.**

Check any of the below you currently take:

laxatives, if yes how many/day

diuretics, if yes name

\_\_\_ diet aids, if yes which ones/s

**FOOD ALLERGIES**: \_\_ All Dairy \_\_Milk \_\_\_Wheat \_\_\_Tree Nuts \_\_\_Soy

Others :\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

#### Supplements. Do you take Vitamin, Mineral and or Herbal Supplements? If yes, check all that apply or note other here:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Multivitamin/ Mineral

Vitamin D

Calcium

Iron

Magnesium

Fish Oil

Co enzyme Q10

Glucosamine/Chondroitin Sulfate

#### Teen and Adult Females Only

Date of last Menstrual period Vaginal Discharge Yeast Infections Other

Are you pregnant? Yes No

If pregnant when is your due date? Breastfeeding? Yes No

Hot Flashes Yes No

#### Lifestyle Habits the Patient wishes to Address

What are your personal behavioral concerns as related to your eating habits or your child’s?

No Concerns

Skipping meals

Eating fast

Over Eating/Portion control Restricting foods/depriving Emotional eating

Tension or stress Eat by the clock

Binge and or purge

Fear of weight gain

Food craving

Diet pills/laxatives Fear of weight loss

Inappropriate eating (standing up, watching TV…)

***TEENS AND ADULTS ONLY* . Please Complete this section.**

Was mealtime stressful growing up?

Habits are usually learned from what you have been taught or how life causes us to react. For you check what applies.

\_\_\_\_“Clean”- plate syndrome

Eating fast, rushing meals

Eating alone; not with family

Put on diets/deprived

Food forced

#### Smoking History

Do you have a history of smoking? Yes No

(if yes) How much per day? How many years

#### Alcohol History

Do you drink alcoholic beverages? Yes \_No

(if yes) How many drinks do you have per day? per week?\_

**Caffeine History:** Do you consume more than 2 cups (16oz.) of caffeinated beverages (cola, coffee, Red Bull, etc.) per day? Yes No

#### Behavioral Profile/Goals Self Evaluation (Circle)

|  |  |  |  |
| --- | --- | --- | --- |
| Energy Level: | Below Average | Average | Above Average |
| Depression: | Never | Sometimes | Almost all the time |
| Headaches: | Never | Sometimes | Often |
| Sleep patterns: | Good | Average | Problems |
| Self Esteem: | Good | Average | Poor |
| Stress | Seldom | Weekly | Daily |

**Adult Weight History**

What age ranges did you notice excessive weight gain? or excessive loss

At your current height, what was/is your highest weight? lowest?

Most stable adult weight\_\_\_\_\_\_\_\_\_\_\_\_\_lbs.

Diet History:

Current Special Diet, specify:

#### Stress Profile

What situations are you dealing with at the current time which may be causing undue stress?

Work related issues

School related issues

Time management issues

How do you cope with stress?

Anti-depressants

Hobbies

Exercise

Relaxation Exercises

Yoga

Talk to friends/support system

Marriage Problems other, specify

Family issues

Financial issues

Caffeine

More work

Food

Alcohol

Smoking

Drugs

Other

Estimate the amount of time spent in each of the following areas (in hours per day or week):

Work Home Sleep Friends Family Children

TV or computer or other electronics

Work Environment (if applicable):

Do you have a stressful work environment? yes no Does your employer offer any Health/Wellness Programs?

Nutrition Lectures

Fitness Lectures

Stress Management Lectures

Other

**Activity & Exercise Assessment** Formula for success: F.I.T.

**F**= Frequency **I** = Intensity **T** = Training Exercise Goals- Check all that apply:

Weight Loss

Strengthening

Endurance

Posture and Balance

Flexibility/Stretching

Sports specific goal (name the sport and goal)

Current Injuries/Problem Areas- Check all that apply:

|  |  |  |
| --- | --- | --- |
| Back | Knees Feet | Shoulder |
| Neck | Elbows Hips | Ankles |

Are you currently involved in a regular exercise program? (If yes) Check all that apply:

Weight training Martial Arts

Walking Yoga

Pilates

Running Dance Aerobic Biking Swimming \_\_\_Tennis

Stretching Machines (Treadmills, Stair climbers, Cross trainers)

\_\_\_other, specify:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many minutes do you exercise per session?

5-15 16-20 21-30 31-45 46-60 over 60 minutes

Number of times per week? \_1-2 3-4 5-6 7+

***I attest that the above information is true and agree to the terms set forth.***

Signature:\_ Date:

If possible, please email a scanned copy this to [la@lifefocusnutrition.com](mailto:la@lifefocusnutrition.com) before your visit and ***PLEASE*** ***BRING THIS ORIGINAL COPY TO YOUR FIRST VISIT.***

***Thank you for your interest in my services and look forward to working with you!***

***Sincerely,***

***Linda Arpino, RDN, CDN, FAND***

**Food Record**

**Name:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Email:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Record all foods and beverages consumed. Keep track for 3 days; 2 days during the week and one weekend day. They do **NOT** have to be consecutive days. Rate Hunger as 0 not hungry and 5 as very hungry!!

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| **Date** | **Time** | **Food Item &**  **Method of Preparation(Steam, Broiled, etc.)** | **Portion size/**  **amount eaten** | **Degree of**  **Hunger 0-5** | **Mood** | **Physical Activity/**  **Exercise** |
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