New Client Information, Waivers, and Cancellation Policy

Sue Rose, MS, RD, LDN
Comprehensive Nutrition Services
847.692.3438

Date _____

Name _____ Birth date _____

Address _____ Apt. # _____

City _____ State _____ Zip _____

Home phone _____ Work phone _____ Cell phone _____

E-Mail _____

Marital Status Married ☐ Single ☐ Other ☐ _____ Sex M ☐ F ☐
(please specify)

PHYSICIAN INFORMATION-Referring Physician or Primary Care Physician (If applicable)

Name _____

Address_____

City _____ State _____ Zip _____

FEES and CANCELLATION POLICY

Fees for services are due at the time services are rendered. I do not bill private insurance companies, but a receipt is available for you to attempt reimbursement to yourself by contacting your health insurance company and filing your own paperwork. I accept payment in the form of cash, check, or credit cards (Visa/MasterCard/Discover).

Sue Rose, MS, RD, LDN is not a Medicare provider and therefore, does not accept Medicare as payment for services rendered.

There is a **24-hour notice cancellation policy**. Messages may be left on the weekend as well. If this notice is not provided, I understand that I will be charged for the cancelled appointment if 24 hours notice is not provided. ___✔___YES_____NO

If I am canceling a previously paid for appointment as part of a package of sessions, I understand that I will forfeit the appointment already paid for when less than 24 hours notice is provided. ___✔___YES _____NO

I understand that if I purchase a pre-paid package of nutrition appointments and do not follow through on those unused appointments, there is no refund. ___✔___YES_____NO

Date _____Client signature _____

HIPPA AUTHORIZATION

In order to be compliant with HIPPA, please indicate your approval of being contacted by phone or e-mail to confirm your appointment as deemed necessary. ___✔___YES _____NO

Sue Rose, MS, RD, LDN reserves the right to disclose information to sources that she deems necessary to protect your health. Additionally, if you have a nutrition related medical condition, your primary care physician or specialist will receive documentation of your nutrition services unless you decline this correspondence. I understand my physician or appropriate health care provider will receive documentation and this is acceptable. ___✔___YES _____ NO

Date _____Client signature _____

NUTRITION, HEALTH, and LIFESTYLE INFORMATION

1. Please describe *any* past diets you have tried:

Jenny Craig	☐	Low Fat	☐
Weight Watchers	☐	High Fiber	☐
Seattle Sutton	☐	Low Calorie	☐
Low Carb	☐	Low Sugar	☐
Other	☐	Describe _____	

2. How often do you eat carry out or restaurant food per **week**?

Never	☐	3-5 x	☐
1-2 x	☐	Daily	☐

3. How often do you grocery shop every **week**?

Never	☐	3-5 x	☐
1-2 x	☐	Daily	☐

4. How often do you cook each **week**?

Never	☐	3-5 x	☐
1-2 x	☐	Daily	☐

5. Please list current medical problems, symptoms, or specific health concerns?

6. Do your immediate relatives have a history of:

Cancer	☐	Specific Type (s) _____
Heart disease	☐	
High blood pressure	☐	
Diabetes	☐	
Gastrointestinal problems	☐	
Osteoporosis	☐	

7. If you have had any surgery, please describe and note approximate year.

8. Do you have any past hospitalizations? If so, please describe below:

9. Please provide a list of your current medications and dosages, if applicable.

10. Please list your nutritional supplements and dosages, if applicable.

11. If you have food allergies or foods you cannot tolerate, please note:

12. Do you eat in response to any particular emotion or stress? If so, please describe:

13. What leisure time activities do you enjoy?

14. Do you do any structured exercise? If so, please describe (treadmill, outside walking/biking, elliptical, video). How long do you exercise?

15. I have exercise equipment at home □ Yes □ No