ENVISION DIETETICS LLC
Fueling for a Better Tomorrow

Rebekah Gaydosh, RDN, LD
205-259-8690
2825 7th St, Tuscaloosa, AL 35401

New Client Registration Form

CLIENT INFORMATION:

Last Name: _____ First Name: _____ Middle Initial: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____

Birth Date: ____/____/_____ Age: ____ Race: _____ Preferred Language: _____ Email: _____

Employer: _____ Occupation: _____ Telephone #: _____

Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widow (check one)

EMERGENCY CONTACTS:

Name: _____ Relationship to Client: _____

Home Phone: _____ Cell Phone _____

Name: _____ Relationship to Client: _____

Home Phone: _____ Cell Phone _____

PRIMARY CARE PHYSICIAN INFORMATION:

Primary Doctor's Name: _____ Telephone #: _____

PAYMENT INFORMATION (Only for no-show or late cancelation fees):

Card Type: _____ (Visa, MC, Discover, & AmEx) Card Holder Name_____

Card Number: _____ Expiration (MM/YY) _____/_____CVV:_____

Billing Address: _____ City: _____ State: _____ Zip: _____

OTHER:

Reason for Visit: _____

Referred by: _____

Today's Date: ____/____/_____

ENVISION DIETETICS LLC
Fueling for a Better Tomorrow

Rebekah Gaydosh, RDN, LD
205-259-8690
2825 7th St, Tuscaloosa, AL 35401

Client Medical and Nutrition Information Intake Forms

Medical Information:

Major Nutrition Concern(s): _____

Height: _____ Weight: _____ Usual Weight: _____ Weight at High School Graduation: _____

Lowest/Highest Weight in Last 5 Years: _____/_____

Current Medications: _____

_____

Current Supplements: _____

_____

Do you have a history of intestinal problems, such as bloating, excessive gas, constipation, or diarrhea?

_____

_____

Do you take laxatives? _____

Do you have any food allergies or intolerances? _____

Do you smoke cigarettes? _____ If YES, how many years? _____ Number per day: _____

Do you drink alcohol? _____ If YES, for how many years? _____Drinks a week: _____

Medical History (Illnesses, Surgeries):_____

Family Medical History: _____

Past Diet History:_____

Exercise (How Often/ Type/ Duration): _____

Have you recently experienced any of the following (please check if YES):

☐ dizziness ☐ fainting ☐ shortness of breath ☐ chest pain ☐ blood in stool

☐ blood in vomit ☐ prolonged/painful constipation or diarrhea ☐ inability to keep down food/fluids

For Women Only - Menstrual History: Age at first menstrual cycle: _____ Is your cycle regular? ☐ YES ☐ NO

Are you on any form of birth control? ☐ YES ☐ NO Date of last menstrual cycle: _____

Eating Information:

Have you seen a dietitian before? ☐ YES ☐ NO If so, When? _____

How many meals and snacks do you eat per day? _____ Meals _____ Snacks

Do you ever skip meals? ☐ YES ☐ NO

If YES, please explain: _____

Do you have times during which you eat uncontrollably? ☐ YES ☐ NO

If YES, please explain: _____

Do you ever eat because you are (please check if YES):

☐ lonely ☐ bored ☐ stressed ☐ anxious ☐ sad ☐ depressed ☐ happy

☐ tired ☐ angry

Do you eat (please check if YES):

☐ in your car ☐ in bed ☐ watching tv ☐ on the computer ☐ reading ☐ standing up

☐ sitting down ☐ when not hungry

Which do you enjoy more?

☐ Eating alone ☐ Eating with others

Is your eating different when you're alone versus when you're with other people? ☐ YES ☐ NO

If YES, please explain:_____

Do you:

☐ eat quickly ☐eat slowly ☐ take large bites ☐ eat with enjoyment ☐ eat without enjoyment

Do you chew your food well before you swallow? ☐ YES ☐ NO

Do you read Nutrition Fact Labels: ☐ YES ☐ NO

If YES, what do you look for on the label? _____

Who does the cooking in your house? _____ Do you know how to cook? ☐ YES ☐ NO

Who does the grocery shopping? _____

Do you have enough money for food? ☐ YES ☐ NO

ENVISION DIETETICS LLC
Fueling for a Better Tomorrow

Rebekah Gaydosh, RDN, LD
205-259-8690
2825 7th St, Tuscaloosa, AL 35401

Office and Payment Policy

Rebekah Gaydosh, RDN, LD

Welcome! I look forward to helping you achieve your health and nutrition goals. Making positive changes to your lifestyle is the cornerstone of good health. This is my office and payment policy, which will help familiarize you with my practice.

Consultations:

The initial visit is 60 minutes. Follow up visits are 30 to 45 minutes. Office visits must end on time, so please arrive on time to your appointments.

Please bring a three day-food record with you to your visit along with all the appropriate paperwork filled out. All forms are available at www.envisiondietetics.com. If you have had any recent lab work done, bring the results from that with you as well.

Cancellations:

If you need to cancel your visit, you must do so at least 48 hours prior to the visit. Otherwise, you will be charged $50.00 for the visit. The same fee applies if you do not cancel or do not show up for an appointment.

I have received, read, and understand the consultation and cancellations policy of Envision Dietetics LLC.

Signature of Patient: _____

Date: _____

HIPAA Authorization for use or Disclosure of Health Information

I. My Authorization

I authorize Envision Dietetics LLC to use or disclose the following health information.

☐ - All of my health information

☐ - None of my health information

☐ - Only my health information relating to the following treatment or condition:

_____

Envision Dietetics LLC may disclose this health information to the following recipient:

Name (or title) and organization _____

Street Address: _____ City: _____ State: _____ Zip: _____

Phone _____ Fax _____ Email _____

This authorization ends:

☐ - On (date)_____

☐ - When the following event occurs: _____

II. My Rights

I understand that I have the right to revoke this authorization, in writing, at any time, except where uses or disclosures have already been made based upon my original permission. In order to revoke this authorization, I must do so in writing and send it to the appropriate disclosing party.

I understand that uses and disclosures already made based upon my original permission cannot be taken back.

I understand that it is possible that information used or disclosed with my permission may be re-disclosed by the recipient and is no longer protected by the HIPAA Privacy Standards.

I understand that treatment by any party may not be conditioned upon my signing of this authorization (unless treatment is sought only to create health information for a third party or to take part in a research study) and that I may have the right to refuse to sign this authorization.

Signature of Patient: _____

Date: _____

Notice of Privacy Policy

Effective Data 3/20/2020

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

If you have any questions about this notice, please contact:

Envision Dietetics LLC
Rebekah Gaydosh, RDN, LD
2825 7th St, Tuscaloosa, AL 35401
205-259-8690
rlgaydosh@envisiondietetics.com

OUR LEGAL DUTY

We are required by applicable federal and state law to maintain the privacy of your health information. We reserve the right to change our privacy. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available. You may request a copy of our Notice at any time. For more information about our privacy practices or for additional copies of this Notice, please contact us using the information at the top of the page.

USE AND DISCLOSURE OF HEALTH INFORMATION

Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment for Services: We may use or disclose your health information to obtain payment for services we provide to you.

Healthcare Operations: We may use or disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, case management, review the competence or qualification of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing and other activities.

Require By Law: We will disclose your health information about you when required to do so by federal, state or local law.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe you are a victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose this type of information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.

Business Associate: We may disclose information to business associates who perform services on our behalf (such as billing companies;) however, we require them to appropriately safeguard your information.

Appointment Reminders: We may use or disclose your health information to contact you as a reminder (such as a voicemail messages, email, postcards, or letters) that you have an appointment for treatment or medical care with Envision Dietetics LLC.

PATIENT/CLIENT RIGHTS

Access: You have the right to inspect and copy your health information, with limited exceptions. Submit your request in writing to Envision Dietetics LLC. A fee will be charged for the costs associated with your request. There are certain situations in which we are not required to comply with your request. In these circumstances, we will respond to you in writing, stating why we will not grant your request and describe any rights you may have to request to review of our denial.

Disclosure Accounting: You have the right to request that we amend your health information. (Your request must be in writing and it must explain why the information should be amended.) We may deny your request under certain circumstances.

Restrictions: You have the right to request we place additional restrictions on our use of your health information. We are not required to agree to additional restrictions, but if we do, we still abide by our agreement (except in an emergency).

Alternative Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by email. To request alternative communications, you must make your request in writing. We will accommodate all reasonable requests. You have the right to a paper copy of this Notice at any time by contacting Envision Dietetics LLC.

QUESTIONS AND COMPLAINTS

If you want more information about our privacy practices or have questions or concerns, please contact us at the above contact information. If you are concerned that we may have violated your privacy rights or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use of disclosure of your health information or to have use communicate with you by alternative means or at alternative locations, you may record your complaint to us by using the contact information at the beginning of this Notice. You also may submit a written complaint to the Secretary of the Department of Health and Human Services. We support your right to the privacy of your health information. If you file a complaint, we will not take any action against you or change our treatment of you in any way. We support your right to the privacy of your health information.

Receipt of Privacy Practices Notice

Please read the copy of Envision Dietetics' Notice of Privacy Practices (above).

Your signature with date acknowledges that you have received and read Envision Dietetics' Notice of Privacy Practices.

Signature_____

Print Name_____

Date _____