REIDENBACH NUTRITION, LLC
Ann Reidenbach, MPH, RD, CD
3142 Mallard Cove Lane
Fort Wayne, IN 46804-2882
Phone: 260.433.3877 Fax: 260.755.5731

Child and Adolescent Intake Information

Date: _____

How did you hear about Reidenbach Nutrition, LLC?
_____
_____

Childs Name _____ Age _____ Sex _____
Home Address _____
City _____ State _____ Zip Code _____
Home Phone _____ Social Security Number _____
Date of Birth _____ Is child adopted? Yes / No If so, at what age? _____

Mother's Name _____
Social Security Number _____ Date of Birth _____ Age _____
Mother's Address (if different from child) _____
Mother's Home Phone _____ Cell/ Business Phone _____
Occupation _____ Employer _____

Father's Name _____
Social Security Number _____ Date of Birth _____ Age _____
Father's Address (if different from child) _____
Father's Home Phone _____ Cell/ Business Phone _____
Occupation _____ Employer _____

Please describe the reason for your visit _____
_____
_____

Family and Household Composition: (List child's immediate family and significant relationships. In *Location* column, write *H* for people living with child and write city/state of residence for people not living with child. Under *Health Issues*, write any serious illnesses or injuries people have)

Name	Relationship	Age	Location	Health Issues (specify)

Please list any significant stressors that your child or your family have experienced (accidents, deaths, moves, school or job change, illness or injury, violence, crime victimization, legal matters, etc.) _____
_____
_____
_____
_____

Parent/Guardian Marital Status:
Parent's Marital Status: €Never Married €Married €Separated €Divorced €Widowed
If child's parents are separated or divorced, Years married _____
If child's parents are separated or divorced, Years separated _____ Years divorced_____
Who does child currently live with? _____
Who is the child's legal guardian?_____
Does the non-custodial parent have access to release of information? _____
Do we have permission to release information to the non-custodial parent?_____
Additional information: _____

School child attends _____ City _____
Grade _____Teacher(s) _____
Describe strength and/or problem areas _____
_____
_____

Medical/Mental health:
Please provide the following information on professionals with whom you are currently receiving treatment:

	Therapist	Primary Care Physician	Other MD/Health care member
Name:			
Address:			
Phone:			
Date of Last Visit:			

Please list all medications your child is currently taking and for what purpose:

Medication	Dosage	Purpose	Prescribed By

Please list any previous mental health services (outpatient and/or inpatient) your child has received

Provider/Agency	Dates	Reason	May We Contact?

List any nutrition/ eating pattern/exercise goals you hope your child will achieve as a result of nutrition counseling:
_____
_____
_____
_____
_____
_____
_____
_____
_____

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Consent for Services

Please initial each section and sign below, acknowledging that you have read & agree to the information below.

_____ **Consent to Treatment**

I agree and consent to participate in services provided by Reidenbach Nutrition, LLC. I understand that there are no guarantees concerning the results of my care. If I refuse treatment that is recommended to me by Reidenbach Nutrition, LLC, I will not hold Reidenbach Nutrition, LLC or Ann Reidenbach, MPH, RD, CD responsible for any consequences, and I release them from liability.

_____ **Release of Medical Information**

I authorize Reidenbach Nutrition, LLC to release necessary medical nutrition or other information to the appropriate third parties when I choose to pursue reimbursement for nutrition services provided and/or to facilitate clinical evaluation and treatment.

_____ **Confidentiality Agreement**

I understand that any information which is disclosed to me or in my presence while I am at Reidenbach Nutrition, LLC (including the public common areas of the office) is confidential and that this confidentiality is protected by federal law. Federal regulation prohibits me from making any disclosure of such information without written consent of the person to whom the information pertains. This also includes seeing someone I know and keeping this confidential. By signing below I acknowledge my responsibility for confidentiality during and after my visit(s) to Reidenbach Nutrition, LLC.

_____ **Acknowledgement of Receipt or Declination of Notice of Privacy Practices**

I have been offered a copy of Notice of Privacy Practices. The notice describes how my health information may be used or disclosed. I understand I should read it carefully. I am aware the Notice of Privacy Practices may be changed at any time. Changes will be posted at the office of Reidenbach Nutrition, LLC. _____ Accepted _____ Declined

_____

Client Name

_____

Signature of Client Date

_____

Signature of Guardian/Responsible Party Date

_____

Signature of Witness Date

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Financial Agreement

Please initial each section and sign, acknowledging that you have read and agree to the following information.

_____ **Responsibility for Charges**

I understand that I am responsible for payment in full at the time of service. I understand that if payment is not made for one or more services provided, I will not be scheduled for an appointment until full payment has been received for prior sessions and my account is current or arrangements have been made to bring the account current. I understand that if my account is 90 days past due it will be sent to collections.

_____ Reidenbach Nutrition, LLC will aid in billing my insurance company by providing me with the paperwork needed to submit my claim. I will submit all claims to my insurance company and I will be directly reimbursed from my insurance company. If the insurance company sends payment to Reidenbach Nutrition LLC, Reidenbach Nutrition LLC will reimburse me, assuming that my account is current. In the instance that my account is not current, the insurance payment will be applied to my account and I will be responsible for any remaining charges.

_____ In the event my insurance company provides reimbursement and then bills Reidenbach Nutrition, LLC for over-reimbursing for services, I understand that I am responsible for this amount.

_____ I am fully aware that while Reidenbach Nutrition, LLC may obtain insurance benefit information, this does not guarantee reimbursement from the insurance company and I am responsible for the full fee. In the event that an issue arises, I understand that it is my responsibility to address this issue with my insurance company directly.

_____I understand that should I fail to pay the balance of my account in full for any reason, I am responsible for Reidenbach Nutrition, LLC's reasonable costs of collection, enforcement, and protection of its' rights and remedies under this Agreement, including but not limited to Reidenbach Nutrition, LLC's court costs, attorneys' fees and other legal expenses.

_____ **Fees of Service**

I am fully aware of the fees for service provided by Reidenbach Nutrition, LLC and that payment will be collected at the beginning of each session. I understand that fees are subject to change at any time and that any changes made will be given to me in writing.

Initial Medical Nutrition Therapy (MNT) (60 min)	$100.00
MNT Session (25 min)	$45.00
MNT Session (50 min)	$90.00
MNT Session (75 min)	$135.00
Home visit (50 min)	$150.00
Group MNT Session (75 min)	$50.00

_____ **Cancellation Policy**

I understand that 24 hour notice is required for cancellation of appointments. I understand that I will be charged in full for any cancellations without 24 hour notice and all no shows. Payment will be expected by the next session. I understand that insurance will not usually cover or reimburse for missed appointments.

_____ **Non-Sufficient Funds Policy**

I understand that there will be a $25.00 charge if payment is made to Reidenbach Nutrition, LLC with a non-sufficient check.

_____ **Acknowledgement of Understanding and Receipt**

I acknowledge that I have read and agree to the above contract and I have been given a copy of this contract for my personal records

_____

Client Name (please print) Name of Responsible Party (please print)

_____

Signature of Client/Responsible Party Date

_____

Signature of Witness Date

Nutrition Questionnaire - Teen

Name: _____ Date of Birth _____Today's Date _____

WEIGHT HISTORY

Height_____ Current Weight_____ Desired Weight_____ Last time weighed this_____

Weight changes prior 12 months _____
How often do you weigh yourself? _____

Highest teen weight _____ When _____ Lowest teen weight_____ When_____
What is an easy weight to maintain when not dieting or overeating? _____

Describe your body size/shape:
As a preschooler _____
In elementary school _____
In middle school _____
In high school _____

EATING HISTORY

Describe what hunger feels like to you: _____
Describe what fullness feels like to you: _____
How do you know when to quit eating? _____
Do you often eat when you are hungry? Yes_____ No _____: Often when **not** hungry? Yes _____ No _____
Can you tell the difference between physical hunger and "emotional" hunger? Yes_____ No _____
What is your earliest memory of being concerned about your weight, body shape or what your eat?
_____
_____
_____
When younger, do you remember being a "picky" eater? _____

Circle any of the following that describes your eating patterns:

i) Eat 3 meals each day
j) Eat large portions of food
k) Eat 3 meals with snacks
l) Binge eat (feel out of control when eating)
m) Have food rituals
n) Eat only healthy foods
o) Skip meals (bkfst – lunch –dinner) or fast
p) Frequently take time to prepare meals at home
q) Purge (any behaviors to help you get rid of food eaten or burn calories). If so, list all ways that you purge.
_____

k) Eat a vegetarian diet
l) Eat out at least 5 meals per week
List restaurants:_____
_____
m) Take vitamin/mineral/herbal supplements, energy drinks or bars. List_____
_____
n) Daily cook for others in your home

j) On a special diet for medical reasons (eg. Diabetes, celiac disease, etc.) _____

How many days per week does your family eat meals together? _____ Describe the family meal. (TV on/off, at a table, in what room, who is present, etc.) _____
_____
How would you describe mealtimes with your family?
Always pleasant Usually pleasant Sometimes pleasant Never pleasant
Explain your response: _____
_____
_____

HEALTH HISTORY

Please describe any serious illnesses, injuries or surgeries – past and/or present: _____
_____
_____
_____

Do you have problems with:

e) Constipation? Yes _____ No_____ Describe: _____
f) Diarrhea? Yes _____ No _____ Describe: _____
g) Nausea? Yes _____ No _____ Describe: _____
h) Bloated-ness? Yes _____ No _____Describe: _____

The following section is for females only. Males skip to Activity History.
How old were you when you first started your menstrual cycle? _____ Date of last menstrual period? _____
As you lose weight, do your cycles become irregular or cease? Yes____ No____ If yes, what is that weight? _____

ACTIVITY HISTORY

Describe your current level of activity: _____
_____
_____
Are you training for an athletic event? (5K walk/run, half marathon, etc.)Yes _____ No _____ Do you struggle with over exercising and/or sometimes feel the need to exercise even though tired, too busy, etc? Yes_____ No_____
Are you pleased with your current level of activity? _____ If not, how would you like to change it? _____
_____
_____

List a TYPICAL day of activity and food intake. List time, amounts and types of foods. Also list fluids consumed. List type, intensity and duration of exercise.

	Morning	Mid-day	Evening	Night
FOOD/ FLUID				
ACTIVITY				

Does the above represent a "good" day or a "bad" day of eating? _____ of exercise? _____

List any nutrition/ eating behavior /exercise goals you hope to achieve as a result of nutrition counseling:
_____
_____
_____
_____
_____

HIPAA NOTICE OF PRIVACY PRACTICES

Effective Date*: *February 1, 2012

THIS NOTICE DESCRIBES HOW PROTECTED 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: Ann Reidenbach, MPH, RD, CD
3142 Mallard Cove Lane
Fort Wayne, IN 46804-2882
(Ph) 260-433-3877
(FAX) 260-755-5731

OUR PLEDGE REGARDING PROTECTED HEALTH INFORMATION:

Reidenbach Nutrition, LLC understands that protected health information about you and your health is personal. We are committed to protecting health information about you. This Notice applies to all records of your care generated by Reidenbach Nutrition, LLC.

This Notice will tell you about the ways in which we may use and disclose protected health information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of protected health information. The law requires us to: make sure that protected health information that identifies you is kept private;

- notify you about how we protect protected health information about you;
- explain how, when and why we use and disclose protected health information;
- follow the terms of the Notice that is currently in effect.

We are required to follow the procedures in this Notice. We reserve the right to change the terms of this Notice and to make new notice provisions effective for all protected health information that we maintain by:

- posting the revised Notice in our office
- making copies of the revised Notice available upon request;
- posting the revised Notice on our Web site.

HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU.

The following categories describe different ways that we use and disclose protected health information without your written authorization.

For Treatment. We may use protected health information about you to provide you with, coordinate or manage your medical treatment or services. We also may disclose protected health information about you to people outside Reidenbach Nutrition, LLC who may be involved in your medical care or others we use to provide services that are part of your care. We may use and disclose protected health information to contact you as a reminder that you have an appointment for treatment or medical care at Reidenbach Nutrition, LLC. We may use and disclose protected health information to tell you about or recommend possible treatment options or alternatives or health-related benefits or services that may be of interest to you.

For Payment for Services. We may use and disclose protected health information about you so that the treatment and services you receive at Reidenbach Nutrition, LLC may be billed to and payment may be collected from you, an insurance company or a third party. For example, we may need to give your health plan information about nutrition services you received at Reidenbach Nutrition, LLC, so your health plan will pay us or reimburse you for the service. We may also tell your health plan about the nutrition services you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations. We may use and disclose protected health information about you for Reidenbach Nutrition, LLC health care operations, such as our quality assessment and improvement activities, case management, coordination of care, business planning, customer services and other activities. These uses and disclosures are necessary to run the facility, reduce health care costs, and make sure that all of our patients receive quality care.

For example, we may use protected health information to review our treatment and services and to evaluate the performance of the dietitian who is providing your services. We may also combine protected health information about many Reidenbach Nutrition, LLC patients to decide what additional services Reidenbach Nutrition, LLC should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to doctors, nurses, technicians, medical students, and other Reidenbach Nutrition, LLC personnel for review and learning purposes. We may also combine the protected health information we have with protected health information from other health care facilities to compare how we are doing and see where we can make improvements in the care and services we offer. We may remove information that identifies you from this set of protected health information so others may use it to study health care and health care delivery without learning who the specific patients are. We may also contact you as part of a fundraising effort.

Subject to applicable state law, in some limited situations the law allows or requires us to use or disclose your health information for purposes beyond treatment, payment, and operations. However, some of the disclosures set forth below may never occur at our facilities.

As Required By Law. We will disclose protected health information about you when required to do so by federal, state or local law.

Research. We may disclose your protected health information to researchers when their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your information

Health Risks. We may disclose protected health information about you to a government authority if we reasonably believe you are a victim of abuse, neglect or domestic violence. We will only disclose this type of information to the extent required by law, if you agree to the disclosure, or if the disclosure is allowed by law and we believe it is necessary to prevent or lessen a serious and imminent threat to you or another person.

Judicial and Administrative Proceedings. If you are involved in a lawsuit or dispute, we may disclose your information in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made, either by us or the requesting party, to tell you about the request or to obtain an order protecting the information requested.

Business Associates. 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.

Public Health. As required by law, we may disclose your protected health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

To Avert a Serious Threat to Health or Safety. We may use and disclose protected health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Health Oversight Activities. We may disclose protected health information to a health oversight agency for activities authorized by law. These activities include audits, investigations, and inspections, as necessary for licensure and for the government to monitor the health care system, government programs, and compliance with civil rights laws.

Law Enforcement. We may release protected health information as required by law, or in response to an order or warrant of a court, a subpoena, or an administrative request. We may also disclose protected health information in response to a request related to identification or location of an individual, victims of crime, decedents, or a crime on the premises.

Special Government Functions. If you are a member of the armed forces, we may release protected health information about you if it relates to military and veterans activities. We may also release your protected health information for national security and intelligence purposes, protective services for the President, and medical suitability or determinations of the Department of State.

Correctional Institutions and Other Law Enforcement Custodial Situations. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release protected health information about you to the correctional institution or law enforcement official as necessary for your or another person's health and safety.

Worker's Compensation. We may disclose information as necessary to comply with laws relating to worker's compensation or other similar programs established by law.

Food and Drug Administration. We may disclose to the FDA, or persons under the jurisdiction of the FDA, protected health information relative to adverse events with respect to drugs, foods, supplements, products and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

YOU CAN OBJECT TO CERTAIN USES AND DISCLOSURES

Unless you object, or request that only a limited amount or type of information be shared, we may use or disclose protected health information about you in the following circumstances:

- We may share with a family member, relative, friend or other person identified by you protected health information directly relevant to that person's involvement in your care or payment for your care.
- We may share information with a public or private agency (such as the American Red Cross) for disaster relief purposes. Even if you object, we may still share this information if necessary for the emergency circumstances.

If you would like to object to use and disclosure of protected health information in these circumstances, please call or write to our contact person listed on page 1 of this Notice.

YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU.

You have the following rights regarding protected health information we maintain about you:

Right to Inspect and Copy. You have the right to inspect and copy protected health information that may be used to make decisions about your care. Usually, this includes medical and billing records.

To inspect and copy protected health information that may be used to make decisions about you, you must submit your request in writing *to Ann Reidenbach*. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request, and we will respond to your request no later than 30 days after receiving it. 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 a review of our denial.

Right to Amend. If you feel that protected health information we have about you is incorrect or incomplete, you may ask us to amend or supplement the information.

To request an amendment, your request must be made in writing and submitted *to Ann Reidenbach*. In addition, you must provide a reason that supports your request. We will act on your request for an amendment no later than 60 days after receiving the request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request, and will provide a written denial to you. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- Is not part of the protected health information kept by Reidenbach Nutrition, LLC;
- Is not part of the information which you would be permitted to inspect and copy; or
- We believe is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of protected health information about you. To request this list or accounting of disclosures, you must submit your request in writing to Ann Reidenbach. You may ask for disclosures made up to six years before your request (not including disclosures made before April 14, 2003). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the costs of providing the list. We are required to provide a listing of all disclosures except the following:

- For your treatment
- For billing and collection of payment for your treatment
- For health care operations
- Made to or request by you, or that you authorized
- Occurring as a byproduct of permitted use and disclosures
- For national security or intelligence purposes or to correctional institutions or law enforcement regarding inmates
- As part of a limited data set of information that does not contain information identifying you

Right to Request Restrictions. You have the right to request a restriction or limitation on the protected health information we use or disclose about you for treatment, payment or health care operations or to persons involved in your care. We are not required to agree to your request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment, the disclosure is to the Secretary of the Department of Health and Human Services, or the disclosure is for one of the purposes described on pages 1-2. To request restrictions, you must make your request in writing to *Ann Reidenbach.*

Right to Request Confidential 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 mail.

To request confidential communications, you must make your request in writing to Ann Reidenbach. We will accommodate all reasonable requests.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice at any time by contacting *Ann Reidenbach*.

OTHER USES AND DISCLOSURES

We will obtain your written authorization before using or disclosing your protected health information for purposes other than those provide for above (or as otherwise permitted or required by law). You may revoke this authorization in writing at any time. Upon receipt of the written revocation, we will stop using or disclosing your information, except to the extent that we have already taken action in reliance on the authorization.

YOU MAY FILE A COMPLAINT ABOUT OUR PRIVACY PRACTICES

If you believe your privacy rights have been violated, you may file a complaint with:

The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C.
Phone # 202-619-0257
Fax # 1-877-696-6775

A complaint to the Secretary should be filed within180 days of the occurrence or action that is the subject of the complaint.

If you file a complaint, we will not take any action against you or change our treatment of you in any way.