



Welcome! We are delighted to have you as a new client!

Feel free to call the main number (949.478.2288) or email your Registered Dietitian (RD) with any questions you may have. You may reach Janice at Janice@socalnw.com, Katy at katy@socalnw.com, and Tina at tina@socalnw.com. We look forward to working with you!

Directions & Map To The Office

You can find a map of the office location at www.socalnw.com/contact.

As you arrive, look for the building marked "180." You may park outside or in the underground parking garage in any visitor space. As you enter the building, you will see a fountain in the middle of an outdoor courtyard. Walk past the fountain to the set of suites that includes suite 162. Come through the double glass doors and have a seat in the waiting area.

Your First Appointment

Your first appointment will typically last 90 minutes. Follow-up appointments are usually scheduled for 45 minutes. If requested, we will provide you with a receipt appropriate to submit to your insurance provided.

Cancellation & Payment Policies

Your appointment is a reservation of the dietitian's time, whether you choose to use it or not. If for any reason you are unable to attend your scheduled appointment, our policy is to charge the full appointment fee. To avoid late cancellation or missed appointment fees please contact us at least 24 hours in advance of your scheduled Tuesday through Friday appointment and 72 hours in advance of Monday or weekend appointments.

Patient Information Forms

In order to best serve you at your initial nutrition appointment, we request that the new client packet that follows be completed and returned at least 48 hours before your visit. We only need you to send pages 2 through 7 & 10 through 12. You may keep this page and the notice of privacy practices for your records. You may send the selected pages by scanning/emailing to Janice@socalnw.com, faxing to (949) 209-1860, or mailing to the office (please allow ample time if mailing).

PERSONAL INFORMATION

Name: _____

Date of Birth: _____

Gender: _____ Age: _____

Marital Status: _____ Occupation: _____

Do you have children? _____

If so, what are their ages? _____

Address: _____

Home Telephone: _____

Cellular phone: _____

E-mail address: _____

Parent/Guardian Name (if under 18 years old): _____

Address: _____

Home Telephone: _____

Cell Phone: _____

E-mail address: _____

Emergency Contact: _____

Phone Number(s): _____

Relationship: _____

Have you ever seen a dietitian or nutritionist before? Yes No

If so, were you happy with the experience? Why/why not? _____

How did you hear about Janice Dada/SoCal Nutrition & Wellness?

Google search

Healthpros.com

Yelp

Citysearch

ED Referral

Eatright.org

Referral from _____

What would you like this consultation to address (please check all that apply)?

Diet assessment for overall wellness & disease prevention

Weight management (please circle your goal: weight loss / weight gain/ weight maintenance)

Disordered eating (please specify: _____)

Blood Glucose Control (circle your condition: Pre-Diabetes, Type 1, Type 2, or Gestational Diabetes)

Heart Health (including elevated cholesterol and/or blood pressure)

Women's Health (Please specify: _____)

Sports Nutrition (sport/activity: _____)

Digestive Issues (Please specify: _____)

Diet for Weight Loss Surgery (Please specify type of surgery _____)

Other Concerns: _____

Nutrition Assessment Questionnaire

PERSONAL HEALTH HISTORY (Please check all that apply)

- | | | |
|-------------------------------------------------------|-------------------------------------------------|-------------------------------------------------------------|
| <input type="checkbox"/> Food allergies | <input type="checkbox"/> Osteoporosis | <input type="checkbox"/> Low iron/anemia |
| <input type="checkbox"/> Food intolerance | <input type="checkbox"/> Osteopenia | <input type="checkbox"/> Menstrual irregularities |
| <input type="checkbox"/> Celiac Disease | <input type="checkbox"/> Stress Fracture | <input type="checkbox"/> Depression/anxiety |
| <input type="checkbox"/> Chronic Constipation | <input type="checkbox"/> Overweight/Obesity | <input type="checkbox"/> Frequent headaches/migraines |
| <input type="checkbox"/> Chronic Diarrhea | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Menopause |
| <input type="checkbox"/> Irritable Bowel Syndrome | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Currently pregnant |
| <input type="checkbox"/> Crohn's Disease | <input type="checkbox"/> Diabetes (type: _____) | <input type="checkbox"/> Currently breastfeeding |
| <input type="checkbox"/> Ulcerative Colitis | <input type="checkbox"/> PCOS | <input type="checkbox"/> Lung disease/asthma |
| <input type="checkbox"/> Vegetarian/Vegan | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Surgery (please specify:
_____) |
| <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Cancer (type: _____) | <input type="checkbox"/> Other (please specify:
_____) |
| <input type="checkbox"/> Excessive fatigue/sleepiness | <input type="checkbox"/> Thyroid Disorder | |
| <input type="checkbox"/> Frequent colds/flu | <input type="checkbox"/> High Cholesterol | |

FAMILY HEALTH HISTORY

What conditions (if any) run in your family? _____

OTHER PERSONAL INFORMATION

Current Weight _____ Current Height _____

Weight History over the last 5 years (range) _____ Weight Goal _____

List all medications, pills or drugs you are currently taking, including dosage:

List minerals, herbs and or vitamin supplements you are currently taking, including brand and dosage
(Please bring bottles along to appointment if possible):

How many hours do you sleep each night? _____

On a scale of 1 to 5, how would you rate your current stress level (1 = Lowest, 5 = Highest)? _____

Are you physically active now? Yes No If so, list activities and frequencies:

How would you rate your present energy level? Poor Normal High

EATING HABITS/ NUTRITIONAL HISTORY

- Do you eat breakfast? __Yes __No __Sometimes
- Do you skip meals? __Yes __No __Sometimes
- Do you eat when you are not hungry? __Yes __No __Sometimes
- Would you say that you are an “emotional eater?” __Yes __No
- Have you had any changes in your appetite lately? __Yes __No
- How many times per week do you eat at restaurants? ____ What type of restaurants? _____
- Do you smoke or chew tobacco? __Yes __No If so, how often and for how many years? _____
- Do you feel that you overeat? __Yes __No
- Do you feel that you under-eat? __Yes __No
- Have you lost or gained more than 10 pounds in the past 6 months? __Yes __No __Don't Know
- *Females:* when was your last period or age of menopause? _____
- Do you feel stuffed after your meals? __Yes __No __Sometimes
- On average, how many minutes does it take you to eat a meal? _____
- Describe your usual eating environment (in the car, at a table, at desk, etc) _____
- Are you following a special diet at this time? __Yes __No If so, what type of diet? _____
- Do you have set meal times? __Yes __No If so, what are they? _____
- Do you have any food restrictions, foods you dislike, or foods you choose not to eat?

- Who does the grocery shopping and cooking in your household? _____

Check off the beverages you regularly drink and indicate how much of each you drink per day:

✓	Beverage	Please Specify	Amount per day (ounces)
	Water		
	Soda	Diet or regular	
	Coffee	Filtered, latte, mocha, etc.	
	Tea	Sweetened or Unsweetened	
	Fruit Juice		
	Alcohol	Wine, Beer, Liquor	
	Milk	Whole, 2%, 1%, Skim, Soy, Almond, Rice	
	Sports Drinks	Gatorade, Powerade, G2, Propel	
	Energy Drinks	Red Bull, Monster	
	Smoothies		
	Vitamin Water	Regular, 10 calorie, Zero	
	Other		

NOTICE OF PRIVACY PRACTICES

Effective Date: August 1, 2009

This notice describes how medical information about you may be used and disclosed and how you can obtain access to this information. Please review it carefully.

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

Janice H. Dada
180 Newport Center Drive, Suite 162
Newport Beach, CA 92660

OUR LEGAL DUTY AND COMMITMENT TO PRIVACY

SoCal Nutrition & Wellness is committed to maintaining the privacy of your protected health information, known as PHI. Because of the Health Care Information Portability and Accountability Act, known as HIPAA, we are required by law to provide you with this Notice of Privacy Practices and of our legal duties regarding your PHI.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

We provide each patient (and patient's parent, for patients under 18 years of age) with an authorization form to allow us to provide PHI to your other health professionals and your insurance company when it is necessary to coordinate your treatment, to obtain payment on your behalf or on behalf of one of your other health care providers, or for health care operations (the administration of this practice and our patient services).

We are also required or permitted to provide your PHI without additional authorization in the following situations: to you or your personal representatives upon request; when required by the Secretary of the Department of Health and Human Services and for public health activities; to our business associates; for certain incidental uses or disclosures; for face-to-face communications that we make with you regarding products or services; to provide gifts of nominal value to you or your family; to correctional institutions if you are an inmate; to help prevent or control communicable diseases; to your employer in limited circumstances, typically related to workplace injuries or medical surveillance; for reporting abuse, neglect or domestic violence; for health oversight activities authorized by law (such as civil or criminal investigations, audits, licensure and disciplinary proceedings, etc.); for judicial and administrative proceedings (such as in response to court orders or discovery requests); for law enforcement; to funeral directors, coroners and medical examiners; for purposes of organ, eye or tissue donation; to avoid a serious threat of harm to health and safety; for specialized governmental functions (e.g., military operations; national security); for auditing purposes; for certain research studies; for workers' compensation purposes; for emergencies or disaster relief; to persons involved in your care or payment related to your care; for notification purposes with respect to your care, condition, location or death. We may also contact you about appointment reminders, treatment alternatives or with educational information regarding your health condition. In any other situation, we will ask for your written authorization before using or disclosing any of your PHI. If you sign an authorization to use or disclose information, you can later revoke that authorization to stop further uses and disclosures.

INDIVIDUAL RIGHTS

In most cases, you have the right to look at or obtain a copy of PHI that we maintain about you. We may charge a fee for costs related to your request. We may, under certain circumstances, deny your request

but if we do, you can obtain a review of that denial by another licensed health care professional that we designate. You also have the right to receive an “accounting,” which lists certain instances when we have disclosed PHI about you for reasons other than treatment, payment or healthcare operations. The request can cover a time period no longer than six years from the date of disclosure. Your first request in a 12-month period is free. After that, we may charge for costs related to additional requests. If you believe that information in your record is incorrect, or if important information is missing, you also have the right to request that we correct the existing information, or add the missing information. We have the right to deny such a request under certain circumstances.

You have the right to request that your health information be communicated to you in a confidential manner such as asking that we contact you at work rather than home. You may request that we restrict how we use or disclose information about you for treatment, payment or healthcare operations, or to persons involved in your care (except when specifically authorized by you, when required by law, or in emergency circumstances). We will consider your request for such restrictions, but are only bound by them if we agree to them. To exercise any of the rights described above, please make a request in writing to Janice Dada, Owner/Principal Dietitian of SoCal Nutrition & Wellness.

CHANGES IN OUR NOTICE OF PRIVACY PRACTICES

We may change our privacy practices at any time and the new terms shall apply to all PHI about you that we have at the time of the change and to all PHI about you that we maintain in the future. If we make any material changes, we will change our Notice of Privacy Practices. The changes will not take effect until they are reflected in a revised Notice of Privacy Practices. You may request a copy of our Notices of Privacy Practices at any time.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with SoCal Nutrition & Wellness. You may also send a written complaint to the Secretary of the United States Department of Health and Human Services. A complaint to the Secretary should be filed within 180 days of the occurrence or action that is the subject of the complaint. If you file a complaint, SoCal Nutrition & Wellness will not take any action against you and your treatment will not be changed in any way.

ACKNOWLEDGMENT: RECEIPT OF SoCal Nutrition & Wellness PRIVACY PRACTICES

****Please sign and return this page. Keep the Notice of Privacy Practices (previous 2 pages) for your records.***

Patient Name _____ Date of Birth ____/____/____

Parent/Guardian Name (if patient is under 18 years of age) _____

I acknowledge receiving a copy of the Notice of the SoCal Nutrition & Wellness Privacy Practices on ____/____/____.

Patient Signature (or Parent/Guardian signature if patient is under 18)

For SoCal Nutrition & Wellness use only. If written acknowledgment was not obtained, please explain below:

PAYMENT POLICIES

Payment is due on the day of service by cash, check, or credit card.

Fees for nutrition counseling are as follows (effective 01/2012):

- **New Client Evaluation:** \$205 (90 minutes); \$275 (90 minute home visit within 10 mile radius)
- **Follow-up Visit:** \$90 (45 minutes); \$120 (45 minute home visit)
- **Extended Follow-up Visit:** \$110 (60 minutes); \$140 (60 minute home visit)
- **Follow-up >6 months since last visit:** \$125 (60 minutes)
- **Grocery Store Smart Shopping Tour:** \$150 per 60 minutes (for stores within 10 mile radius)

I understand that:

My payment for nutrition counseling includes RD communication with other members of my treatment team and reasonable phone/e-mail communication with my dietitian at no extra charge. Extensive phone or e-mail communication that replaces follow-up care, whether scheduled or unscheduled, will be billed at the rate of \$45 per quarter hour.

Insurance coverage (other than Medicare Part B for Type 2 Diabetes or Chronic Kidney Disease) is not valid for payment. By signing below, I am acknowledging my understanding of payment responsibility should Medicare not cover the cost of my visit. For PPO insurance and upon request, SoCal Nutrition & Wellness will provide a coded receipt for services (Superbill) that may be submitted to insurance providers for reimbursement.

My appointment is a reservation of the RD's time, keeping other clients from reserving that time. Therefore, even if I do not attend my scheduled appointment, I will be charged for the time reserved. If notice is given in a timely manner (at least 24 hours in advance of Tuesday through Friday appointments and 72 hours in advance of Monday and weekend appointments), I will not be charged.

Credit Card Authorization

Patient Name: _____ Date of Birth: ___/___/___

Credit Card Type (Circle one): Visa Mastercard Discover American Express

Card Number: _____ Expiration Date: ___/___

Last 3 or 4 numbers from front/back of card (CVV2 code) _____

Billing Address & Zip Code _____

My signature below signifies that I have read, understand, and agree to abide by the above policies, and grants my permission for SoCal Nutrition & Wellness to charge my credit card or bill me for any appointment, which is not paid for any reason on the day of service, or for any appointment that is not cancelled in the timely manner as described above.

Signature: _____ Date: ___/___/___

Consent for Treatment & Authorization for use of Protected Health Information

Patient Name: _____ DOB: _____

Parent/Guardian (for patients under 18yo): _____

I hereby consent to participating in nutrition counseling at SoCal Nutrition & Wellness and understand that all information I provide is private, confidential, and protected by law as described in the SoCal Nutrition & Wellness Privacy Practices. When necessary to coordinate my nutrition and healthcare, and as described in the SoCal Nutrition & Wellness Privacy Practices, my protected health information may be obtained from and/or provided to my:

Insurance Company (please specify _____)

Primary Care Doctor: _____

Address: _____

Phone: _____ Fax: _____

Other Doctor: _____

Specialty: _____

Address: _____

Phone: _____ Fax: _____

Other Health Care Professional: _____

Type of Professional: _____

Address: _____

Phone: _____ Fax: _____

SoCal Nutrition & Wellness is hereby released from legal responsibility or liability for the release of information authorized herein. I understand that I have the right to revoke this authorization in writing at any time by sending notification to SoCal Nutrition & Wellness. I understand that I have the right to (1) inspect or obtain a copy of the protected health information to be provided as permitted under federal and state law, and (2) refuse to sign this authorization. My signature below indicates my understanding and acceptance of the above policies.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____
(if patient is under 18 years old)