

IM

Scales Nutrition and Wellness Center

Patient Registration

Referring Physician (if applicable):

Patient's Last Name

Patient's First Name

MI

Spouse/Parent (Please circle)

Address

Apartment No.

Name

City, State, Zip Code

Address

Home Phone

Cell Phone

City, State, Zip Code

Email

Phone Number

Date of Birth

Social Security

Insurance Information

Primary Insurance

Sex (Please Circle)

Marital Status (Please Circle)

Name of Insurance Carrier

Male Female

Married Single

Divorced Widowed

ID Number

Group Number

Driver's License Number

State

Secondary Insurance

Name of Employer

Phone No.

Name of Secondary Insurance

Name of Emergency Contact

Phone No.

ID Number

Group Number

Privacy Practices (Please Initial Each Line)

_____ I acknowledge that Dr. Scales office personnel has given me a copy of their Notice of Privacy Practices. I authorize Dr. Scales and/or his office personnel to communicate with family, friends, or other health care providers as to my medical conditions. Listed below are the (specific) family members or health care providers to whom I give permission to discuss my health status.

_____ The following listed names are (specific) family members or health care providers with whom I Do Not want my medical conditions discussed.

_____ I authorize Dr. Scales or his office personnel to leave messages on my voice mail at home and work, or email.

_____ I authorize other physicians or health care providers I have seen to exchange medical information with Dr. Scales, unless otherwise indicated.

Financial & Insurance Policy (Please Initial Each Line)

_____ I hereby authorize payment of benefits processed on by behalf to Scales Nutrition & Wellness Center for any services furnished to me by Dr. Scales. Furthermore, I authorize Dr. Scales and his office personnel to release any information obtained in the course of my evaluation & treatment to permit processing of claims for insurance reimbursement. I understand I am responsible for payment of any service(s) my insurance does not pay or process in a timely matter, customarily in 60 days.

_____ I understand I am financially responsible for paying my co-payments, co-insurance, deductibles and all outstanding balances. In the event that any past due balance is placed with a third party, I agree to pay any cost of such collection including the agency fees, legal/attorney fees and court cost.

_____ I understand if I cancel my appointment within 24 hours of the scheduled appointment or fail to keep a scheduled appointment, I will be charged and responsible for paying twenty-five (\$25) dollars for an internal medicine & medication management appointment, seventy (\$70) dollars for a psychiatry appointment, fifty (\$50) dollars for a therapy appointment, and appropriate charge(s) for a missed nutrition appointment.

Signature of Patient (Parent or guardian if patient is a minor)

Date

Scales Nutrition and Wellness Center

1010 Fourth Avenue North, Nashville, TN 37219 (615) 724-0865

Your rights:

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding; and protected health information that is subject to law that prohibits access to protected health information.

You may have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not to be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively, i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to the Secretary of Health and Human Services or us if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. We will not retaliate against you for filing a complaint.

This notice was published and becomes effective on **April 14, 2003.**

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at (615) 724-0865.

Signature below is only acknowledgement that you have received this notice of our Privacy Practices:

Print name _____ Signature _____ Date _____

**Scales Nutrition and Wellness Center
Patient Questionnaire, Page 1 of 4**

Date: _____

Name: _____

Age: _____

Occupation: _____

Marital Status: M S D W

Please indicate if you have suffered any of the following:

<input type="checkbox"/> Asthma	<input type="checkbox"/> Jaundice	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Stroke
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Gout	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Tuberculosis
<input type="checkbox"/> Bladder Infections	<input type="checkbox"/> Goiter	<input type="checkbox"/> Hernia	<input type="checkbox"/> Ulcer
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Glaucoma	<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Cancer
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Hay Fever	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Psychiatric Disorder

Other Medical Problems not noted above: _____

List any Hospitalizations for illness, trauma, or surgery below, please give reason and date of hospitalization:

DATE:	Reason for Hospitalization:

Medications: Please list all medications including over the counter medications, antacids, laxatives, birth control pills, vitamins, herbs, etc.

Drug	Dose	How many times per day?	Length of time taken

Allergies: Are you allergic to any medications, latex, or foods? If so, Please list them and the problem that you experienced.

Medication/Food Allergy	Problem Experienced

Name _____

Date _____

**Scales Nutrition and Wellness Center
Patient Questionnaire, Page 2 of 4**

Vaccinations within the past ten years (please include date it was given):

Tetanus (TT, Td, or DPT) _____ MMR: _____
 Pneumovax: _____ Hepatitis B: _____
 Influenza: _____ HIB: _____

Health Maintenance Date (include dates if known):

PPD (for TB) _____ Flexible Sig/Colonoscopy: _____
 Hemocult: _____ Pap Smear/PSA: _____
 Mammography: _____ Breast/Testes: _____
 Stress Test: _____ EKG: _____
 Chest X-ray: _____ Echocardiogram: _____

Personal Health Habits:

Do you smoke?	Y	N	How many years? _____
Have you ever smoked?	Y	N	How many years? _____
			How many packs per day? _____
Do you drink alcohol?	Y	N	How many drinks per week? _____
			Date of last drink: _____
Do you exercise regularly?	Y	N	What kind of exercise? _____
			How often? _____
Do you use recreational drugs?	Y	N	What kind? _____
			How often? _____
Do you have any problems sleeping?	Y	N	How many hours nightly? _____
Do you follow a special diet?	Y	N	What kind? _____
Have you ever been exposed to Toxins or fumes at home/work?	Y	N	What kind? _____

Review of Symptoms:

Have you had any of the following problems? If so, which ones and when did they start?

General:	No	Yes	When/Explain
Skin/rash	___	___	_____
Bruise easily	___	___	_____
Joints ever painful?	___	___	_____
Lost or Gained weight?	___	___	_____
Sensitive to Heat/Cold	___	___	_____
Head and Neck			
Frequent Headaches	___	___	_____
Frequent Cold's	___	___	_____
Problems with Vision	___	___	_____
Hearing	___	___	_____
Frequent Nosebleeds	___	___	_____
Hair Loss	___	___	_____
Difficulty Seeing at Night	___	___	_____
Taste Alteration	___	___	_____
Bleeding Gums	___	___	_____
Dry Mouth	___	___	_____
Sores in Mouth	___	___	_____

Name: _____

Date: _____

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	No	Yes	When/Explain
Chest and Cardiovascular			
Shortness of breath	_____	_____	_____
Wheezing	_____	_____	_____
Chest Discomfort	_____	_____	_____
Extremities Cold/Numb	_____	_____	_____
Swelling of Hands/Feet	_____	_____	_____
Frequent Coughing	_____	_____	_____
Coughing up Blood	_____	_____	_____
Daytime Drowsiness	_____	_____	_____
Loud snoring	_____	_____	_____
Unrested after Sleep	_____	_____	_____
Gastrointestinal			
Stomach Pains	_____	_____	_____
Frequent Nausea	_____	_____	_____
Frequent Constipation	_____	_____	_____
Black Stools	_____	_____	_____
Blood or Pus in Stool	_____	_____	_____
Vomiting Blood	_____	_____	_____
Frequent Diarrhea	_____	_____	_____
Trouble Digesting food	_____	_____	_____
Frequent Laxative Use	_____	_____	_____
Genitourinary			
Urinate >1 time/night	_____	_____	_____
Urinate >6 times/day	_____	_____	_____
Burning during urination	_____	_____	_____
Urine Brown or Bloody	_____	_____	_____
Sexual Difficulties	_____	_____	_____
Musuloskeletal			
Knee Problems	_____	_____	_____
Back Problems	_____	_____	_____
Leg Cramps	_____	_____	_____
Joint Pain	_____	_____	_____
Change in Mobility	_____	_____	_____
Neurological			
Dizziness	_____	_____	_____
Memory Loss	_____	_____	_____
Tremors	_____	_____	_____
Seizures	_____	_____	_____
Headaches/Migraines	_____	_____	_____

Name: _____

Date: _____

