Lifestyle Management Solutions

Welcome!
I am happy to have you as a new client and look forward to working with you. Should you have any questions, feel free to call (626) 963-5350 or email LMS@GinaCrome.com.

Your First Appointment
Your first appointment will be about 90 minutes in length. Follow-ups are usually scheduled for 1 hour. I will provide you with a receipt appropriate to submit to your insurance provider if you wish to do so.

Cancellation & Payment Policies
In order to maintain the integrity of our practice, we must request that all cancellations be made with a minimum of 24-hour notice. Failure to provide 24-hour notice or a failure to show will result in your account being charged for the visitation at our standard fee.

Client Information Forms
In order to best serve you at your initial nutrition appointment, please print and complete your new client packet that follows prior to your first visit.

Lifestyle Management Solutions

Client Information

Name_____
First Middle Last

Address_____
Street City State Zip

Home Phone:_____Cell:_____E-Mail:_____

Age_____ Date of Birth ____/____/____ Sex: M/F Social Security Number _____-_____-_____

Occupation or Profession: _____Employer _____

Emergency contact: _____Relation:_____

Phone:(_____)_____Address:_____

Insurance Provider_____ Phone:(_____)_____

ID #_____ Group # _____

How did you hear about Lifestyle Management Solutions?
❑Google Search ❑Yelp ❑EatRight.org
❑Physician Referral ❑Friend/Family Member ❑Other _____

What would you like this consultation to address? (please check all that apply)
❑Diet Assessment for General Wellness/Disease Prevention
❑Weight Management: Please circle one: Weight Loss Weight Gain Weight Maintenance
❑Disordered Eating-please specify:_____
❑Blood Glucose Control: Please circle one: Pre-Diabetes Type 1 Type 2 Gestational Diabetes)
❑High Blood Pressure
❑Elevated Cholesterol and/or Triglyceride Levels
❑Women's Health-please specify: _____
❑Sports Nutrition-please specify sport/activity: _____
❑Digestive Issues-please specify: _____
❑Diet for Weight Loss Surgery-please specify type of surgery:_____

PERSONAL HEALTH HISTORY (Please check all that apply)

❑Asthma	❑Food allergies	❑Irritable Bowel	❑Other (please specify)
❑Cancer	❑Food intolerance	❑Low iron/anemia	_____
❑Celiac Disease	❑Frequent colds/flu	❑Menopause	_____
❑Chronic constipation	❑Frequent headaches	❑Osteoporosis	
❑Crohn's Disease	❑Heart Disease	❑Osteopenia	
❑Currently pregnant	❑High Blood Pressure	❑Overweight/Obesity	
❑Currently breastfeeding	❑High Triglyceride	❑PCOS	
❑Depression/anxiety	❑High Cholesterol	❑Surgery (describe:_____)	
❑Diabetes (type: _____)	❑Hyperthyroidism	❑Ulcerative Colitis	
❑Eating Disorder	❑Hypothyroidism	❑Vegetarian	

Height _____ Current Weight _____ Weight Goal _____ Weight Range (past 3 years) _____-_____

Do You Have Trouble Sleeping? ❑Yes ❑No 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 Yes, please list activities & frequency:

_____

_____

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

Primary Care Physician & Name of Clinic:_____

Medical Conditions:_____

_____

_____

_____

_____

Current Medications

Medication/Dosage	Reason for Use	Medications/Dosage	Reason for Use
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Previous surgeries (dates/procedure):_____

_____

Serious injuries or illnesses:_____

_____

Do you have any allergies that you know of? ❒Yes ❒No If Yes (please specify):_____

Which, if any, of your blood relatives have had any of the following?

❒ Arthritis	❒ Diabetes	❒ Osteoporosis/Osteopenia
❒ Bleeding Disorders	❒ Heart Disease	❒ Stroke
❒ Cancer	❒ High Blood Pressure	❒ Tuberculosis

NUTRITIONAL INFORMATION

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 kind 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
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 please describe _____
Do you have set meal times? ❑Yes ❑No If so, please specify_____
Do you have any food restrictions, dislikes or foods you choose not to eat for any reason?

_____

3-Day Food Diary

Instructions

Complete the following food record prior to your first appointment. This 3-day diary is designed for recording three *consecutive* days, including one weekend day if possible. Please record ALL food and drinks at each time of the day you eat or drink. Waiting till the end of the day to fill in your diary will result in lost information. Make sure you fill in as much detail as possible. Include any vitamins, minerals, sports or herbal supplements you are taking. Being as specific as you can about the food type and amounts will help us provide you with a more accurate assessment. Should you have any questions, please feel free to contact our office (626) 963-5350.

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FOOD DIARY: DAY 1 DATE:_____

BREAKFAST	AMOUNT	ITEM(S)
TIME:		
SNACK(S)		
TIME:		
LUNCH		
TIME:		
SNACK(S)		
TIME:		
DINNER		
TIME:		
SNACK(S)		
TIME:		
PHYSICAL ACTIVITY	DURATION	DESCRIPTION
WATER 		

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FOOD DIARY: DAY 2 **DATE:_____**

BREAKFAST	AMOUNT	ITEM(S)
TIME:		
SNACK(S)		
TIME:		
LUNCH		
TIME:		
SNACK(S)		
TIME:		
DINNER		
TIME:		
SNACK(S)		
TIME:		
PHYSICAL ACTIVITY	DURATION	DESCRIPTION

WATER 

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FOOD DIARY: DAY 3 **DATE:_____**

BREAKFAST	AMOUNT	ITEM(S)
TIME:		
SNACK(S)		
TIME:		
LUNCH		
TIME:		
SNACK(S)		
TIME:		
DINNER		
TIME:		
SNACK(S)		
TIME:		
PHYSICAL ACTIVITY	DURATION	DESCRIPTION
WATER 		

24-HOUR CANCELLATION AND PAYMENT POLICY

In order to maintain the integrity of our practice, we must request that all cancellations be made with a minimum of 24-hour notice. Failure to provide 24-hour notice or a failure to show will result in your account being charged for the visitation at our standard fee.

Payment is due on the day of service by cash, check, or major credit card. The client or client's representative agrees to pay Lifestyle Management Solutions for services rendered in accordance with the regular rates and terms. Insurance clients please note that payment is due at the time of services rendered and will be reimbursed upon receipt for the amount covered by your insurance plan.

I authorize this office to release any information to my insurance carrier via this provider's designated medical billing clearinghouse as necessary to process my claim.

X_______ **X**_____

Signature of Client Date Signature of Representative Date

CLIENT CONSENT FORM

The Department of Health and Human Services has established a "Privacy Rule" to help insure that personal health care information is protected for privacy. The Privacy Rule was also created in order to provide a standard for certain health care providers to obtain their client's consent for uses and disclosures of health information about the client to carry out treatment, payment, or health care operations.

As our client we want you to know that we respect the privacy of your personal medical records and will do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest; this includes third party claims processing services.

We also want you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not clients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain client consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we have the right to refuse to treat you should you choose to refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer. You have the right to review our privacy notice, to request restrictions and revoke consent in writing after you have reviewed our privacy notice.

_____ **X**_____

Client Name (please print) Client Signature Date

Compliance Assurance Notification For Our Clients

The misuse of Personal Health Information (PHI) has been identified as a national problem causing clients inconvenience, aggravation, and money. We want you to know that all of our providers continually undergo training so that they may understand and comply with government rules and regulations regarding the Health Insurance Portability and Accountability Act (HIPAA) with particular emphasis on the "Privacy Rule." We strive to achieve the very highest standards of ethics and integrity in performing services for our clients.

It is our policy to properly determine appropriate use of PHI in accordance with the governmental rules, laws and regulations. We want to ensure that our practice never contributes in any way to the growing problem of improper disclosure of PHI. As part of this plan, we have implemented a Compliance Program that we believe will help us prevent any inappropriate use of PHI.

Our policy is to listen to our employees and our clients without any thought of penalization if they feel that an event in any way compromises our policy of integrity. More so, we welcome your input regarding any service problem so that we may remedy the situation promptly. Thank you for being one of our highly valued clients.

Client Acknowledgement Confirming Receipt of HIPAA Privacy Notice

I have received Lifestyle Management Solutions HIPAA Privacy Notice.

_____ **X**_____

Client Name (please print) Client Signature Date

Consent for Treatment & Authorization For Use of Protected Health Information

Client Name: _____ DOB: _____
Parent/Guardian (for clients under 18 years of age)_____

I hereby consent to participating in nutrition counseling with Lifestyle Management Solutions and understand that all information I provide is private, confidential, and protected by law as described in the Lifestyle Management Solutions privacy practices. When necessary to coordinate my nutrition and healthcare, and as described in the Lifestyle Management Solutions privacy practices, my protected health information may be obtained from and/or provided to my:

❑Insurance Company: _____

❑Primary Care Doctor: _____
Address: _____
_____
Phone: _____ Fax: _____

❑Other Doctor: _____
Specialty: _____
Address: _____
_____
Phone: _____ Fax: _____

❑Other Health Care Professional: _____
Type of Professional: _____
Address: _____
_____
Phone: _____ Fax: _____

Lifestyle Management Solutions 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 Lifestyle Management Solutions. 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.

Client Signature: _____ Date: _____

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

HIPAA NOTICE OF PRIVACY PRACTICES

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:

Lifestyle Management Solutions (626) 963-5350

OUR PLEDGE REGARDING PROTECTED HEALTH INFORMATION:

Lifestyle Management Solutions 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 of the records of your care generated by *Lifestyle Management Solutions* personnel or your personal doctor.

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 may disclose protected health information about you to doctors, nurses, technicians, medical students, or other Lifestyle Management Solutions personnel who are involved in taking care of you.

Lifestyle Management Solutions staff may also share protected health information about you in order to coordinate the different things you need, such as prescriptions, lab work and x-rays. We also may disclose protected health information about you to people outside Lifestyle Management Solutions who may be involved in your medical care, such as clergy 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 the Lifestyle Management Solutions. 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 the Lifestyle Management Solutions 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 Lifestyle Management Solutions 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 Lifestyle Management Solutions 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 Lifestyle Management Solutions patients to decide what additional services the Lifestyle Management Solutions 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 Lifestyle Management Solutions 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 PHI 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.

Organ and Tissue Donation. If you are an organ donor, we may release protected health information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

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.

Coroners, Medical Examiners, and Funeral Directors. We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also disclose protected health information to funeral directors consistent with applicable law to enable them to carry out their duties.

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 also share information to notify these individuals of your location, general condition or death.
- 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 Gina M. Crome*. 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 Gina M. Crome*. 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 Lifestyle Management Solutions;
- 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 Gina M. Crome. 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 3-4.

To request restrictions, you must make your request in writing to Gina M. Crome.

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 Gina M. Crome. 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 Gina M. Crome.

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 Gina M. Crome or file a written complaint with the Secretary of the 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, we will not take any action against you or change our treatment of you in any way.