soolman NUTRITION LLC

# New Patient Forms

Please complete the enclosed forms and return them to our office via one of the four following methods.

- **Mail** them to Soolman Nutrition LLC, 36 Bonwood Road, Needham, MA 02492.
- **Drop** them outside our office door (same location as our mailing address) in a sealed envelope to protect your privacy.
- **Fax** them to 781-433-0471.
- **Scan and email** them to info@soolmannutrition.com. In order to avoid any potential compatibility issues, please only send PDF files.

**As soon as we have received and reviewed your paperwork, we will contact you to schedule your initial visit.**

Please note that completion of the enclosed food diary is optional. Completion of the enclosed eating disorder questionnaire is required if applicable to your care, but otherwise can be skipped.

You deserve to understand the paperwork you are completing. If you have any questions or concerns about these forms, please ask and we will be happy to help.

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# New Patient Registration

## Patient Information

Name: _____ Gender: _____

What would you like us to call you? _____

Date of birth (mm/dd/year): _____ Preferred pronouns: _____

Address: _____

***Please circle your preferred contact method below.***

Email: _____ Daytime telephone: _____

Cellphone: _____ Evening telephone: _____

## Emergency Contact Information

Name: _____ Relationship to patient: _____

Daytime telephone: _____ Evening telephone: _____

## Primary Care Physician

Name: _____ Telephone: _____

Address: _____

## Referral

Do you have a referral from your doctor? ☐ yes (if yes, complete line below) ☐ no (if no, skip line below)

Authorization number: _____ Number of visits authorized: _____

## Health Insurance Information

Primary insurance: _____ Telephone: _____

Insurance ID number: _____ Group number: _____

Policy holder's name: _____ Policy holder's date of birth (mm/dd/year): _____

Policy holder's address: _____

Policy holder's relationship to patient: ☐ self ☐ parent ☐ spouse ☐ other: _____

Co-pay amount: $_____

## E-Newsletter

Each month, we distribute via email our free e-newsletter in which we discuss current topics in nutrition and share news about our practice. Recipients can easily unsubscribe at any time. If you wish to receive it, please check here: ☐

Patient Signature: _____ Date: _____

***If the patient is an unemancipated minor or otherwise incapacitated (physically or mentally), complete the following.***

Signature of Personal Representative: _____

Description of Authority: _____

Date: _____

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## Billing and Cancellation Policy

- Soolman Nutrition LLC accepts Blue Cross Blue Shield, Harvard Pilgrim Health Care, Tufts Health Plan, Aetna, Cigna, and United. Because insurance plans vary from person to person, ultimately it is the patient's responsibility to contact their insurance company prior to the first appointment to determine their coverage for nutrition services. All appointments not covered by insurance must be paid for in full by the patient. The out-of-pocket fee is $150.00 per 50-minute session.
- Patients are requested to make all payments, including co-pays, at the time of service. Patients may make their payments via cash, check, or credit card. Please make all checks payable to Soolman Nutrition LLC.
- For telehealth appointments, the patient must be physically present in Massachusetts at the time of their appointment. In order to utilize insurance, the patient must be on camera for the session, not just represented by a family member or caretaker. If the patient is not on camera, the appointment must be paid for in full by the patient.
- For in-person appointments, the patient must be physically present for the session, not just represented by a family member or caretaker, in order for insurance to be utilized. If the patient is not present, the appointment must be paid for in full by the patient.
- All appointment cancellations must be completed at least 24 hours in advance. Failure to cancel an appointment with at least 24-hours notice or not showing up to an appointment without any notice will result in a $150.00 fee that must be paid by the patient (i.e. this fee will not be covered by insurance). If a patient is 20 or more minutes late to an appointment, the appointment will be considered canceled and the patient will be required to pay the $150.00 fee.
- If you have an in-person appointment scheduled and you are sick, please reschedule your appointment. In the event that you cancel due to illness, you will not be charged a fee. However, you must alert your practitioner that you will not be keeping the appointment due to illness. If you fail to show up without any notice or do not cite illness as your reason for cancelling, you will be charged the above-mentioned fee. By signing below, you are promising to only cite illness as your reason for cancelling if you are actually sick.

**By signing below, I acknowledge that I have read, understand, and agree to the above policy.**

Printed name: _____

Patient Signature: _____ Date: _____

***If the patient is an unemancipated minor or otherwise incapacitated (physically or mentally), complete the following.***

Signature of Personal Representative: _____

Description of Authority: _____

Date: _____

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# New Patient Questionnaire

***Joanne Levy Soolman, MS, RD, LDN***

Full Name:_____ Gender:_____ DOB (Month/Day/Year):_____

Occupation:_____

How did you hear about Soolman Nutrition LLC?_____

Have you ever worked with a dietitian/nutritionist? ☐Yes ☐No If yes, what was your experience? _____

_____

**Medical History:**

Please list/describe any physical health concerns/medical conditions that you have (e.g. high blood pressure, Crohn's disease, diabetes, etc.):_____

_____

_____

Please list your current medications and supplement dosages:_____

_____

_____

Please check off any symptoms you have experienced over the past month:

| | | | |
|---|---|---|---|
| ☐ abdominal bloating | ☐ headaches | ☐ heart palpitations | ☐ other: _____ |
| ☐ constipation | ☐ heartburn / acid reflux | ☐ nausea | ☐ other: _____ |
| ☐ diarrhea | ☐ fainting | ☐ poor concentration | ☐ other: _____ |
| ☐ fatigue | ☐ dizziness | ☐ vomiting | ☐ other: _____ |

**Dietary Habits:**

How many meals a day do you eat? ☐ less than 1/day ☐ 1-3 per day ☐ more than 3/day

Describe your snacking habits (e.g. frequency, time of day, types of foods):_____

_____

Please list any special diets you might follow (i.e. vegetarian, vegan, gluten-free, etc.): _____

_____

Please list any food allergies/intolerances/sensitivities you know, or suspect, you might have: _____

_____

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Who does the grocery shopping in your home?

Who prepares the food at home?

Do you go out to eat? If so, how often?

What foods do you love?

What foods do you dislike?

Do you feel like your diet has a lot of variety, or do you feel like you tend to eat the same things every day?

**Physical Activity:**

What types of physical activity do you enjoy?

**Nutrition and Wellness Goals:**

What would you like to accomplish during our first visit?

What are some short-term goals you would like to work on?

What are some long-term goals you would like to work on?

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# Eating Disorder Questionnaire

Name: _____

How often do you weigh yourself? ☐ 1-3x/day ☐ daily ☐ weekly ☐ monthly ☐ occasionally ☐ rarely ☐ never

Do you restrict how much you eat? ☐ Yes ☐ No

Do you have "safe" foods? If so, please list: _____

_____

Do you have "fear" foods? If so, please list: _____

_____

Have you ever/do you currently binge? ☐ Yes, currently ☐ Yes, in the past ☐ No

Frequency: ☐ more than 3 times/day ☐ 1-3 times/day ☐ more than 3 times/week ☐ less than 1 time/week ☐ never

Have you ever/do you currently purge? ☐ Yes, currently ☐ Yes, in the past ☐ No

Frequency: ☐ more than 3 times/day ☐ 1-3 times/day ☐ more than 3 times/week ☐ less than 1 time/week ☐ never

Have you ever/do you use exercise primarily as a way to control your weight? ☐ Yes, currently ☐ Yes, in the past ☐ No

How often do you exercise? ☐ daily ☐ 1-3 times/week ☐ less than 3 times/week ☐ never

Have you ever/do you currently use ☐ laxatives ☐ diuretics ☐ diet pills?

Frequency (day/week): _____

When did these behaviors begin for you? _____

_____

Are there any other eating/weight/compensatory behaviors we should know about? _____

_____

_____

_____

Have you ever been hospitalized/admitted for treatment for an eating problem? ☐ Yes ☐ No

Please list the treatment facility/facilities name(s) and dates you were a patient/resident there: _____

_____

_____

_____

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# Food Diary

Before our first appointment, it would be very helpful if you could keep a record of what you eat and drink for two or three days (ideally two weekdays and one weekend day) and send in the record *prior to our first appointment* (i.e. with your other patient forms).

Let me stress that this is just to help me understand what, how much and how often you eat, *not to place any sort of judgment on you*!

For many people it can be difficult to write down what they eat, but please do your best. If you are unable to do this prior to our first appointment, we can complete it together.

The next few pages are a food record/diary format that might be helpful for you, but feel free to keep track however feels most convenient or comfortable for you (e.g. in a notebook, on your smartphone, on a computer spreadsheet). Again, please send in this food record/diary *before our first appointment*.

Thank you!

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Name: _____

Date: _____

| Time | Food | Amount | Feelings/Comments |
|---|---|---|---|
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Name: _____

Date: _____

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Name: _____

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# NOTICE OF PRIVACY PRACTICES

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

This Notice describes the privacy practices of Soolman Nutrition LLC (the "Practice"). The Practice is required by law to maintain the privacy of medical and health information about you ("Protected Health Information" or "PHI") and to provide you with this Notice of the Practice's legal duties and privacy practices with respect to PHI. When the Practice uses or discloses PHI, the Practice is required to abide by the terms of this Notice (or other notice in effect at the time of the use or disclosure).

**How the Practice May Use and Disclose Your PHI**

The following categories describe ways the Practice may use and disclose your PHI (however, not every use or disclosure in a category is listed). Your written authorization is not required before the Practice may use or disclose your PHI for the purposes listed below, unless otherwise noted.

**Treatment –** The Practice uses PHI to provide treatment and other services to you – for example, nutrition counseling. With your consent, the Practice may disclose information about you to other health care providers who are involved in your care and treatment.

**Payment –** The Practice may use, and with your consent, disclose your PHI so that the services you receive may be billed and payment collected from you, an insurance company or third party payor. For example, the Practice may disclose your PHI to file claims and obtain payment from your health insurer for the nutrition counseling services provided by the Practice. With your consent, the Practice also may disclose PHI to other health care providers so that they may seek payment for services they rendered to you.

**Health Care Operations –** The Practice may use, and with your consent, disclose your PHI as necessary to support the day-to-day activities and management of the Practice. For example, the Practice may use and disclose your PHI for purposes of internal administration and planning, quality review and improvement, legal services, etc.

**Information Related to Your Care –** The Practice may use your PHI to communicate with you about products or services relating to your treatment, case management or care coordination, or alternative treatments, therapies, providers or care settings. The Practice also may use your PHI to identify health-related services and products provided by the Practice that may be beneficial to your health and then contact you about the services and products. The Practice will not use or disclose your PHI for purposes of marketing (as defined by federal privacy laws) without first obtaining your prior authorization.

**Communication with Family and Others –**The Practice may disclose your PHI to a family member, other relative, close personal friend or others who are identified by you, who are involved in your care or payment for your care, when you are present for, or otherwise available prior to, the disclosure, and you do not object to such disclosure after being given the opportunity to do so. The Practice also may disclose your PHI to such person with your verbal agreement or written consent. If you are incapacitated or in an emergency circumstance, the health care providers at the Practice may exercise their professional judgment to determine whether a disclosure is in your best interest. If



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the Practice discloses PHI in such event, the Practice would disclose only PHI that we believe is directly relevant to the person's involvement with your health care or with payment related to your health care. The Practice also may disclose your PHI in order to notify (or assist in notifying) such persons of your location, general condition or death.

**Public Health Reporting –** Your PHI may be disclosed for public health purposes as required by law.

**Health Oversight Activities –** Your PHI may be disclosed to health oversight agencies as required by law. Health oversight activities include audit, investigation, inspection, licensure or disciplinary actions, and civil, criminal or administrative proceedings or actions. The Practice also is required to disclose your PHI to the Secretary of Health and Human Services, upon request, to determine our compliance with the Health Insurance Portability and Accountability Act.

**Health or Safety –** The Practice may use or disclose PHI to prevent or lessen a serious and imminent danger to you or to others if the disclosure is to a person who is reasonably able to lessen or prevent the threat, including the target of the threat.

**Judicial and Administrative Proceedings –** The Practice may disclose PHI in the course of a judicial or administrative proceeding in response to a legal order or other lawful process.

**Law Enforcement Officials –** Your PHI may be disclosed to the police or other law enforcement officials as required or permitted by law or in compliance with a court order or a grand jury or administrative subpoena accompanied by a court order.

**Specialized Government Functions –** The Practice may use and disclose your PHI to units of the government with special functions, such as the U.S. military or the U.S. Department of State under certain circumstances as required by law.

**Ordered Examinations –** The Practice may release your PHI when required to report findings from an examination ordered by a court or detention facility.

**Decedents –** The Practice may disclose your PHI to a coroner or medical examiner as authorized by law.

**Organ and Tissue Procurement –** If you are an organ donor, the Practice may disclose your PHI to organizations that facilitate organ, eye or tissue procurement, banking, or transplantation.

**Research –** The Practice may use or disclose your PHI without your consent or authorization for research purposes if an Institutional Review Board/Privacy Board approves a waiver of authorization for such use or disclosure.

**Required by Law –** The Practice may use and disclose your PHI when required to do so by federal, state or local law.

**Sale of PHI, Marketing, and Other Uses and Disclosures Require Your Authorization –** The Practice will not sell your PHI or otherwise use or disclose it for purposes of marketing (as defined by federal privacy laws) without obtaining your prior written authorization. Furthermore, use or disclosure of your PHI for any purpose other than those listed above requires your written authorization or that of your legal representative. We will not deny services to you if you do not sign the authorization. Furthermore, you may revoke the authorization at any time, in writing. If you revoke your authorization, we will no longer use or disclose information about you for the reason covered by your written revocation.

**Highly Confidential Information –** Federal and state law require special privacy protections for certain highly confidential information about you ("Highly Confidential Information"), including: (1) your HIV/AIDS status; (2) genetic testing information; (3) substance abuse (alcohol or drug) treatment or rehabilitation information; (4)



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confidential communications with a psychotherapist, psychologist, social worker, sexual assault counselor, domestic violence counselor, or other allied mental health professional, or human services professional; (5) venereal disease information; (6) mammography records; (7) mental health community program records; (8) research involving controlled substances; (9) abortion consent form(s); and (10) family planning services. In order for us to disclose your Highly Confidential Information, we must obtain your separate, specific written consent and/or authorization unless we are otherwise permitted by law to make such disclosure. If you are an emancipated minor, certain information relating to your treatment or diagnosis may be considered "Highly Confidential Information" and as a result will not be disclosed to your parent or guardian without your consent. Your consent is not required, however, if a physician reasonably believes your condition to be so serious that your life or limb is endangered. Under such circumstances, we may notify your parents or legal guardian of the condition, and will inform you of any such notification. Please note that if you are a parent or legal guardian of an emancipated minor, certain portions of the emancipated minor's medical record (or, in certain instances, the entire medical record) may not be accessible to you.

**Your Rights Regarding Your PHI**

Although your health records are the physical property of the Practice, you have certain rights with regard to the information we maintain about you in those records.

**Notice –** You have the right to receive a paper copy of this Notice (even if you have agreed to receive this Notice electronically).

**Revoke Your Authorization –** You have the right to revoke your authorization (or consent) to our use/disclosure of your PHI, as long as you make your request in writing to the Practice. You can revoke your authorization (or consent) for future disclosures, but not for any disclosures made prior to when you first gave your authorization (or consent).

**Request Restrictions –** You have the right to request restrictions on uses and disclosures of your PHI: (i) for treatment, payment and health care operations; (ii) to individuals (such as a family member, other relative, close personal friend or any other person identified by you) involved with your care or with payment related to your care, or (iii) to notify or assist in the notification of such individuals regarding your location and general condition. The Practice will consider your request; however, we are not required to agree to the restriction (with one limited exception relating to disclosures to a health plan where you pay out of pocket in full for the health care item or service). Restrictions we have agreed to do not apply to disclosures that are made mandatory by health oversight activities or law. Requests must be submitted in writing to the Practice.

**Receive Confidential Communications –** You have the right to receive confidential communications of your PHI from the Practice by alternative means or at alternative locations. We are required to accommodate any reasonable request you make. Requests must be submitted in writing to the Practice.

**Inspect and Copy Your PHI –** You have the right to inspect and copy your PHI that we hold in a designated record set. This usually includes medical records (excluding psychotherapy notes) and billing records. To the extent that electronic health records are available, you have a right to an electronic copy of your record, and, if you choose, to direct us to transmit a copy of the electronic health record to a designated individual or entity. We may charge a fee for copies of your records. Please contact Jonah Soolman for information about fees and to request a copy of your records.

**Amend Your PHI –** You have a right to request that we amend your PHI if you feel that the information we have is inaccurate or incomplete, as long as the Practice created the information you wish to amend. We will not make changes to medical information created by another health care provider or changes that would make your medical record inaccurate or incomplete. Requests must be submitted in writing to the Practice.



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**Accounting and Access Report –** You have a right to receive a list of how and to whom certain of your medical information has been disclosed during a period of time up to six years prior to the date of your request for that list, called an "accounting of disclosures". The accounting does not include disclosures of your PHI that pertain to treatment, payment or health care operations. To the extent that we use or maintain your PHI in an electronic designated record set, you also have a right to receive an access report indicating who has accessed such PHI (including access for purposes of treatment, payment, and health care operations) during a period of time up to three years prior to the date of your request. We will provide an access report relating to such disclosures made by us and all of our Business Associates. Requests for an accounting and requests for an access report must be submitted in writing to the Practice.

**Notice of a Breach –** You have a right to receive a breach notification that complies with applicable Federal and State laws and regulations in the event of a breach of your unsecured PHI.

**Security Cameras**

For security purposes, video cameras record the exterior of the office property and the private property. The cameras that monitor the office property – that is, the driveway, the path leading to the office, the landing outside the office door, and the stairs and wheelchair lift leading to said landing – record video, but not audio. The cameras that monitor the private property – that is, all other areas not previously mentioned – capture both audio and video. Recordings are password protected and stored in the cloud, from which they are automatically deleted on a regular basis. No recordings of any kind are taken within the office. We kindly ask that you stay within the office property and refrain from entering private property; your entrance on private property indicates your consent to audio recordings.

**Revisions to the Practice's Privacy Policies and Practices**

The Practice is required by law to: make sure that the privacy of your PHI is maintained, provide you with this Notice of our legal duties and privacy practices, and abide by the terms of the Notice that is currently in effect. The Practice reserves the right to change its privacy policies and practices, including this Notice, and to make the new policies and practices, including the revised Notice provisions, effective for all PHI that we maintain. We will post a copy of the current Notice in our office. You may request a copy of it at any time.

**Questions Regarding the Privacy of Your Health Information**

If you have questions regarding information contained in this Notice, if you would like to obtain additional information about our privacy practices, or if you wish to exercise your rights as listed in this Notice, you may contact Jonah Soolman.

**How to File a Complaint**

If you would like to submit a comment or complaint about our privacy practices, you can do so by contacting Jonah Soolman. You may also contact the Secretary of the Department of Health and Human Services. You will not be penalized or otherwise retaliated against for filing a complaint.

Regional Manager
Office for Civil Rights
U.S. Department of Health and Human Services
Boston Regional Office – Region 1



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Government Center
J.F. Kennedy Federal Building – Room 1875
Boston, MA 02203
Email: OCRComplaint@hhs.gov
FAX: (617) 565-3809
TDD: (800) 537-7697

**Practice Contact Information**

Jonah Soolman is the Practice's Privacy Official. You may contact him and other Practice staff at:

Phone Number: (781) 433-0470
Fax Number: (781) 433-0471
Email Address: info@soolmannutrition.com
Mailing Address: 36 Bonwood Road, Needham, MA 02482

*Effective Date*
*This revised Notice is effective as of November 7, 2018.*
*The original Notice was adopted as of June 7, 2012.*

soolman NUTRITION LLC

# Acknowledge and General Consent

Patient Name: _____
*Last* *First* *Middle*

Home Address: _____

_____

Date of birth (mm/dd/year): _____

**ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:**

By my signature below, I hereby acknowledge that I have received a copy of the Practice's Notice of Privacy Practices.

**CONSENT TO DISCLOSE MY GENERAL HEALTH INFORMATION:**

By my signature below, I hereby authorize the Practice to disclose my health information so that the Practice may treat me, seek payment from third parties for such treatment, and generally carry on the health care operations of the Practice (e.g., quality assurance). I also authorize the Practice to disclose my health information to insurers and providers outside of the Practice when necessary for purposes of my treatment, payment for that treatment, and for their health care operations.

**CONSENT TO DISCLOSE MY HIGHLY CONFIDENTIAL INFORMATION:**

I understand that my health information currently contains or may contain in the future the following types of highly confidential information, and by my signature below, I specifically consent to the disclosure of the following types of highly confidential information so that the Practice may treat me, seek payment from third parties for such treatment, and generally carry on the health care operations of the Practice (e.g., quality assurance):

- information about genetic testing
- information related to confidential communications with a psychotherapist, psychologist, social worker, sexual assault counselor, domestic violence counselor or other allied mental health professional or human services professional
- information about venereal disease(s)
- abortion consent form(s)
- mammography records
- information about family planning services
- if I am an emancipated minor, information about my treatment and diagnosis for which I have consented as an emancipated minor (except that this information shall not be disclosed to my parents)
- information about research involving controlled substances

*(I have struck any and all information listed above that I do not want the Practice to disclose.)*

I also authorize the Practice to disclose such information to insurers and providers outside of the Practice when necessary for purposes of my treatment, payment for that treatment, and for their health care operations. I have struck any and all information listed above that I do not want the Practice to disclose.


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**CONSENT TO ADDITIONAL DISCLOSURES:**

*Some patients wish to involve family, friends, or personal trainers in their care. If you would like to authorize the Practice to disclose your information to such individuals involved in your care, please list them below. Alternatively, you may indicate "none" if you wish.*

By completing this section and by my signature below, I authorize the Practice to disclose my general health information (and my highly confidential information if necessary) to the following family members (e.g., spouse, children) and/or friends:

| Name | Relationship to me |
|---|---|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

**CONSENT TO METHODS OF COMMUNICATION:**

By completing this section and by my signature below, I authorize the Practice to communicate with me in the following manner *(check each that applies)*:

☐ Home phone using the following number: _____.

- ☐ Please check here if the Practice may leave a voice mail message (with general health information and highly confidential health information if necessary) at this number.

☐ Cell phone using the following number: _____.

- ☐ Please check here if the Practice may leave a voice mail message (with general health information and highly confidential health information if necessary) at this number.
- ☐ Please check here if the Practice may text you (using general health information and highly confidential health information if necessary) at this number.

☐ Email using the following email address: _____.

Patient Signature: _____ Date: _____

***If the patient is an unemancipated minor or otherwise incapacitated (physically or mentally), complete the following.***

Signature of Personal Representative: _____

Description of Authority: _____

Date: _____



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# Treatment Team

**Check the box next to the name of your provider(s) at Soolman Nutrition LLC:**

☐ Joanne Levy Soolman, MS, RD, LDN

☐ Jonah Soolman, RD, LDN, ACSM EP-C, NSCA-CPT

As providers at Soolman Nutrition LLC, we frequently consult with one another and also consult with other members of your treatment team in connection with the development, implementation, and evaluation of your individual treatment plan and related matters. To facilitate those communications, please list the members of your treatment team below, together with their contact information.

| Provider Type | Provider Name / Credentials | Contact (Telephone / Email) |
|---|---|---|
| Primary Care Physician* (i.e. MD, DO, NP) | | |
| Therapist* (i.e. PhD, PsyD, LICSW) | | |
| Case Manager (include facility name) | | |
| Other (i.e. Personal Trainer, Chiropractor, etc.) | | |

*****_Please note that our ability to communicate with your primary care physician (PCP) and any therapist you may have is a critical component of the care we provide and we cannot treat you in the absence of such communications. We understand that your communications with your PCP and therapist may be highly sensitive in nature. Please be assured that our communications with your PCP and therapist will be limited to information that is relevant to your nutritional care._

In the event that any of the information above changes at any time, please let us know so that your list can be updated as needed.

Patient Name: _____ Date: _____