130 Second Avenue, Waltham, MA 02451
781-434-6578 781-370-2330 (fax)
www.domarcenter.com

# General Information for Patients Receiving Nutrition Counseling

1. Due to federal privacy regulations, we are not allowed to exchange clinical information in email. You can email your nutritionist anything you want, but if she needs to give you any clinical information back she will need to call you. The nutritionist usually checks email only on the days she is in the Center.

2. If you need to reach your nutritionist, please call the Domar Center administrative assistant at 781-434-6578. She can communicate messages to the nutritionist throughout the week.

3. If you need to cancel or reschedule your appointment, **please give at least 48 hours notice**. There is a $95 self-pay late cancellation or no-show charge. ***Please be aware our reminder calls are a courtesy only.***

4. Everything we discuss in our sessions remains totally confidential and your records are kept in a locked file.

5. When you leave a message please remember to leave a call back number, even if you think we have it. And please speak slowly!

6. If you need your nutritionist to return a call to you, you need to be explicit in your message if you do not want a message left. Otherwise, we will just say that "--------- returned your call."

7. Doctor's insurance authorizations are expected at the time of the visit otherwise you will be billed. For special circumstances, arrangements may be made with the nutritionist directly not to exceed 3 business days.

I have read and understand this information:

Name: ____________________________________ Date: _______________

# Insurance Script

We realize that working with insurance can seem overwhelming and at times frustrating. The purpose of this script is to give you guidance in negotiating the insurance process and ensure that our time together is covered by your insurance plan. ***We ask that you complete each step before your first appointment and bring this document with you to your first appointment.***

| Primary Insurance & Policy # | | | | Group # | |
|---|---|---|---|---|---|
| Policy Holder, Name | | DOB | | Relationship to Client | |
| Policy Holder, Address | | | | Self Spouse Parent Other | |

| Secondary Insurance & Policy # | | | | Group # | |
|---|---|---|---|---|---|
| Policy Holder, Name | | DOB | | Relationship to Client | |
| Policy Holder, Address | | | | Self Spouse Parent Other | |

***Steps to take PRIOR to your apt:***

1. Call the member services number on the back of your card. Here are some important questions to ask.

- Does my plan cover outpatient nutrition counseling? Yes No
  - If yes, how many how many sessions are allowed? ______________________
  - Does my plan only cover visits that are considered "medically necessary"? Yes No
- Do I have a deductible to meet first? Yes No If yes, how much? __________________
- Do I need a physician referral? Yes No
  - Note, if you need a physician referral this must be done at least 1 week prior to our session. You may need to provide the referral office information located at the bottom of this form.
- What is my co-pay amount for outpatient nutrition counseling? ________ Note: nutrition counseling is sometimes considered as a "specialist" and the co-pay may be different than what is listed on your card.

2. Bring your insurance card with you to your first appointment.

3. Don't hesitate to contact us if you have any questions or concerns

**Hillary's billing is done through an organization called Good Measures so please use their NPI number - 1427487917** **Note: Hillary accepts Blue Cross Blue Shield, Harvard Pilgrim, Tufts, Aetna, United and Cigna insurances as a form of payment. However, if you are contracted with another insurance company we are more than happy to provide you with a superbill to submit to your insurance company for reimbursement for our sessions. ***The superbill does not guarantee reimbursement.***

# PATIENT REGISTRATION FORM

_____ New Client ______ Change of Client Information Effective Date: _________

**Provider: Hillary Wright, MEd, RD, LDN**

## Personal Information

Name ____________________________________________
Address ____________________________________________
City, State, Zip ____________________________________________
Home Phone ____________________________________________
Work phone ____________________________________________
DOB ____________________________________________
Sex ____________________________________________
Social Security ____________________________________________
Marital status ____________________________________________

## Health Insurance Information

Insurance Company ____________________________________________
Insurance Co. Address ____________________________________________
Insurance Co. City, State, Zip ____________________________________________
Insurance Co. Phone ____________________________________________
Identification # ____________________________________________
Subscriber Name ____________________________________________
Subscriber DOB ____________________________________________
Relationship to Patient ____________________________________________
Subscriber Employer ____________________________________________
Group # ____________________________________________
Secondary Insurance Co. ____________________________________________
Secondary Insurance ID# ____________________________________________
Pre-certification # ____________________________________________
# of sessions Pre-certified ____________________________________________

**Authorization to Pay Insurance Benefits:** I hereby direct my insurance carrier t make payments directly to the Provider for health insurance benefits otherwise payable to me, but not to exceed the Provider's regular charges of $150.00/60 minutes. I understand that I am financially responsible for charges not covered by this authorization (including insurance copayments and deductibles that are due at the time of service). This assignment of benefits shall be valid for the duration of my treatment.

Signature of Patient/Guardian: _______________________ Date: ___________________

**Authorization For Release of Information:** I hereby authorize the Provider and his office billing staff or agency to release billing and medical information to my insurance company necessary to process claims for services rendered to me by the Provider. This authorization is limited to the release of only that information necessary to substantiate and process health insurance claims and excludes such confidential information, which by law may only be released by specific consent.

Signature of Patient/Guardian ______________________________ Date ______________

Dx-1______________ Dx-2 ______________ Dx-3 ______________ Dx-4 _____________

**Hillary Wright, MEd, RD, LDN**
**Domar Center for Mind Body Health**

## NEW PATIENT INFORMATION & ACKNOWLEDGEMENT OF FINACIAL RESPONSIBILITIES

**PAYMENT:** Payment is expected at the time of your appointment. Checks are to be made payable to Hillary Wright. If there is any difficulty in making payment at the time of the visit, please negotiate this with the dietitian at the time of the initial evaluation.

**APPOINTMENT:** Individual appointments are scheduled for a specific time. You will charged $95 for missed appointments unless the dietitian is notified of cancellation at least 48 hours in advance, or in cases of emergency. **This cancellation fee assessment includes missed initial appointments**. **Confirmation calls are placed but are considered a courtesy.**

**FEES:** Initial and follow up visits are $150 (all visits are 60 minutes); discount may be available to those without insurance coverage based on need.

**MEDICAL INSURANCE:**

**Insurances accepted include Blue Cross Blue Shield, Harvard Pilgrim Healthcare and Tufts Health Plan.** Medical insurance may or may not offer coverage for outpatient nutrition counseling, so you should carefully investigate the types of coverage you may have. Although you may have insurance that will reimburse you, please understand that it is your responsibility to pay for your visit and to have your insurance company reimburse you if applicable. **It is your responsibility to make sure any referral authorizations needed are completed and submitted to the insurance company prior to the date of your appointment, and to determine what your copay is for your nutrition visit if you have multi-tiered copays.**

**ACKNOWLEDGEMENT OF FINANCIAL RESPONSIBILITIES:** I hereby ensure that the above information is true and correct and recognize responsibility for payment of nutrition counseling services at the time of the session unless prior arrangements have been made with you by Hillary Wright. I understand that the receipt provided to me may be ***self-submitted*** for insurance coverage for potential reimbursement. I understand that I may be charged for appointments not changed or cancelled at least **48 hours** prior to the scheduled time of the appointment.

Signature of responsible party: ______________________________________________

Date: _______________________

- ☐ Payment, minus copayment, has been temporarily withheld pending private insurance reimbursement directly to Hillary Wright, MEd, RD, LDN.
- ☐ Copayment received: $ ______ Form of Payment: Cash/Check # ______

**Patient Written Acknowledgement Confirming Receipt of Privacy Notice:**

I have received Hillary Wright, MEd, RD, LDN's HIPPA Privacy Notice.

____________________________________________ (print patient/client name)

____________________________________________ (patient signature or signature of responsible party)

____________________________________________ (date)

AUTHORIZATION FOR RELEASE OF INFORMATION
FROM YOUR ***PRIMARY CARE PHYSICIAN***

**I authorize:** **HILLARY WRIGHT, MEd, RD, LDN of**
**NEW VISION NUTRITION**
**34 SUNSET ROAD ARLINGTON, MA 02474**
**P: 781-646-9413**
**C: 617-460-0985**

To exchange records with: ______________________________________________
Name of receiving person, agency or institution

______________________________________________
Address

______________________________________________
City State Zip

______________________________________________
Phone Number

In regard to ____________________________________________________________
Name of patient

______________________________ ________________
Signature of responsible party Date

## DOMAR CENTER NUTRITION PRE APPOINTMENT QUESTIONNAIRE

**Please complete to the best of your ability prior to you first appointment**

### WEIGHT HISTORY

| HEIGHT | WEIGHT | HIGHEST ADULT WEIGHT | WEIGHT AT 18-20 YEARS | GOAL WEIGHT |
|---|---|---|---|---|
| | | | | |

| HEIGHT | WEIGHT | BMI | DAILY CALORIES (Maintain) | DAILY CALORIES (Lose) |
|---|---|---|---|---|
| IDEAL BODY WEIGHT | % IDEAL BODY WEIGHT | ADJUSTED WEIGHT | USUAL BODY WEIGHT | % USUAL BODY WEIGHT |

***Dietitian will make these calculations.***

## ***If you are here seeking help with weight management*,**
## which of these methods have you tried for weight loss? ***Circle all that apply*** ***Did it work? Y/N***

a. Dietitian / nutritionist Y N _____
b. Exercise Y N _____
c. Low calorie diet Y N _____
d. Very-low-calorie-diet (i.e., liquid, HMR, protein-sparing, Optifast) Y N _____
e. Formal group diet program (i.e., Weight Watchers, OA) Y N _____
f. Prescription diet drugs ____________________________________ Y N _____
*Please list medications*
g. Over-the-counter diet drugs (e.g. Dexatrim, Hoodia) Y N _____
h. Psychological counseling/behavior modification Y N _____
i. Hypnosis Y N _____
J. Have you ever induce vomiting or use laxatives for weight loss? Y N _____
k. Have you engaged in excessive exercise to help you lose weight? Y N _____

**If you did not maintain your weight loss for at least 1 year, why do you think you were not successful?**

______________________________________________________________________________

**Do any family members struggle with being overweight? *(circle those that apply):*** Father Mother Brother Sister

**Do you…**

Eat differently when you are **alone**? Y N
Eat when you are **upset** or **nervous**? Y N
Eat sweets or salty **snacks**? Y N
Tend to **binge eat**? Y N
Eat in front of the **TV** or **computer**? Y N
Eat meals or snacks in the **car**? Y N
Are you comfortable with the way you eat? Y N

**MEDICAL HISTORY:**

**Do you have any of the following medical problems?**

| | | | |
|---|---|---|---|
| a. | Diabetes mellitus | Y | N |
| b. | High blood pressure | Y | N |
| c. | High cholesterol | Y | N |
| d. | Angina (chest pain) | Y | N |
| e. | History of heart disease | Y | N |
| f. | History of a stroke | Y | N |
| g. | Low back pain | Y | N |
| h. | Arthritis/joint pain | Y | N |
| i. | Sleep apnea (breathing or severe snoring problems at night) | Y | N |
| j. | Other breathing problems | Y | N |
| k. | History of ulcers | Y | N |
| l. | History of heartburn | Y | N |
| m. | Gallbladder disease/gallstones | Y | N |
| n. | History of liver disease | Y | N |
| o. | History of kidney disease | Y | N |
| p. | History of cancer<br>If yes, specify___________________________ | Y | N |
| q. | Thyroid | Y | N |
| r. | Menopause | Y | N |

**Please list all vitamin and herbal products:**

_______________________________________________
_______________________________________________
_______________________________________________

**Please list all present medications and doses:**

_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________

**Please list all allergies or intolerances (i.e., lactose):**

To any foods_________________________________
_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________

To any medications___________________________
_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________
_______________________________________________

**Do you smoke?** Y N **Quantity?** _______________
**If you quit, for how long?** _______________________

**How many hours of sleep do you get each night?**
_______________________________________________

**EATING PATTERNS I:**

**Please pick the number that best describes how much the behavior influences your weight gain.**

**1 = Does not contribute**
**2 = Contributes a small amount**
**3 = Contributes a moderate amount**
**4 = Contributes a large amount**
**5 = Contributes the greatest amount**

_______a. Eating too much food
_______b. Overeating at breakfast
_______c. Overeating at lunch
_______d. Overeating at dinner
_______e. Snacking between meals
_______f. Snacking at night
_______g. Eating because I am physically hungry
_______h. Eating because I crave certain foods
_______i. Eating because I cannot stop once I've begun
_______j. Continuing to eat because I don't feel full after a meal
_______k. Eating because of the good taste of foods
_______l. Eating because of the sight/smell of food
_______m. Eating while cooking or preparing food
_______n. Eating when anxious
_______o. Eating when tired
_______p. Eating when bored
_______q. Eating when stressed
_______r. Eating when angry
_______s. Eating when depressed/upset
_______t. Eating when socializing
_______u. Eating when happy
_______v. Eating when alone

Please write any other factors that you feel may have contributed to your weight gain.

_______________________________________________
_______________________________________________
_______________________________________________

**How many days a week do you eat the following meals?**

| **Meal** | **Days per week** | **Time** |
|---|---|---|
| Breakfast | | |
| Morning snack | | |
| Lunch | | |
| Afternoon snack | | |
| Dinner | | |
| Nighttime snack | | |

**Who prepares meals at home?**_______________________

**Who does the grocery shopping?**_____________________

**Describe your appetite?**
___ Strong, must eat when hungry
___ Variable, sometimes hungry or not; forget to eat if busy
___ Not hungry a lot; OK if I eat just a couple times a day

**Please list the amount of the following you typically drink in a day.**

_______Skim milk

________Low fat milk (2%)
________Whole milk
________Seltzer water
________Tonic water (diet or regular)
________Fruit juice
________Fruit drinks (Hi-C, Sunny D)
________Water
________Coffee ____Cream? _____Sugar?
________Tea (black, green or herbal)
________Sugar-sweetened beverages (soda, Snapple)
________Diet soda or diet beverages
________Alcohol (5 oz wine, 12 oz beer, 1.5 oz liquor)

**During a typical week, how many meals do you eat at a fast-food restaurant?**

Breakfast: ________________ meals per week
Lunch: ________________ meals per week
Dinner: ________________ meals per week

**During a typical week, how many meals do you eat at a traditional restaurant, coffee shop, or cafeteria?**

Breakfast: ________________ meals per week
Lunch: ________________ meals per week
Dinner: ________________ meals per week

**How willing are you to record (online or paper) what you eat and drink?**

| 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|
| **Very** | | **Neutral** | | **Not Very** |

**24-HOUR FOOD RECALL:**

**Please write down all the foods and drinks you ate yesterday, or a typical day if more representative.**

| Meal | Time | Where did you eat this? | Food/drink *(include how prepa* | Amount |
|---|---|---|---|---|
| Morning Meal | | | | |
| Snack | | | | |
| Lunch | | | | |
| Snack | | | | |
| Dinner | | | | |
| Snack/Dessert | | | | |

| Meal | How often do you eat? | Examples |
|---|---|---|
| Breakfast | ___ daily<br>___ most mornings<br>___ 2-3 times a week<br>___ seldom or never | ___ roll, pastry, donut<br>___ cold or hot cereal (oatmeal)<br>___ eggs, sausage, home fries<br>___ fruit and yogurt |
| Snacks | ___ 3 or more a day<br>___ 1-2 a day<br>___ few times a week<br>___ seldom or never | ___ chips, pretzels or nuts<br>___ energy bar or candy bar<br>___ pastries, cookies or other baked sweets<br>___ candy, ice cream |
| Fatty foods | ___ 4 or more a week<br>___ 2-3 times a week<br>___ 2-4 times a month<br>___ seldom or never | ___ hamburgers, hot dogs, lunch meat, steaks, fast food<br>___ cheese, whole milk, yogurt, cottage cheese<br>___ butter, ice cream, chocolate<br>___ cake, pastries, cookies, donut |
| Breads/grains | ___ nearly always eat refined grain product<br>___ eat mostly refined grain product<br>___ eat mostly whole-grain product<br>___ eat only whole-grain product | ___ white bread, rolls, bagels, typical cereals<br>___ regular pancakes and waffles, typical baked goods<br>___ brown rice, quinoa, farro, old-fashioned oats<br>___ whole wheat bread, rolls and bagels |
| Protein | ___ nearly always eat animal protein<br>___ eat mostly animal proteins<br>___ eat mostly vegetable proteins<br>___ eat only vegetable proteins | ___ meats, poultry, fish, cheese, eggs<br>___ legumes (beans and peas), hummus, nut foods<br>___ soy (tofu, tempeh, edamame, veggie burgers/dogs)<br>___ seitain (wheat gluten) |
| Vegetables and Fruits | ___ 5 or more a day<br>___ 2-4 a day<br>___ 1-2 a month<br>___ seldom or never | ___ green (spinach, kale, broccoli, turnip/collards, Swiss chard)<br>___ red (bell pepper, beets, strawberry, apple, tomato, watermelon)<br>___ orange (squash, melon, bell pepper, carrots, orange, grapefruit)<br>___ blue (blueberries, eggplant, blackberry, plum, grapes/raisins) |

**PHYSICAL ACTIVITY:**

**What physical problems, if any, limit your physical activity:**

________________________________________________

________________________________________________

**How much do you enjoy physical activity?**

a. Not at all
b. Moderately
c. Greatly

**Please circle the types of physical activity you enjoy and have participated in during the last year.**

a. Walking (outside or indoors)
b. Yoga (Hatha, power, heated)
c. Jogging
d. Running
e. Biking (outside or indoors)
f. Aerobic movement (DVDs, classes)
g. Tennis
h. Swimming
i. Basketball
j. Golf
k. Dancing
l. Strength training
m. Other:________________________________

**Please circle the best response below (in the past 2 months):**

**FREQUENCY**

4 6 - 7 times per week
3 3 - 5 times per week
2 1 - 2 times per week
1 A few times per month

**INTENSITY**

4 Aerobic activities that result in heavy breathing and sweating (e.g., high impact aerobics, running, speed swimming, distance cycling).
3 Moderate aerobic activity (e.g., normal bike riding, jogging, low impact aerobics).
2 Moderate aerobic activity (e.g., volleyball, moderate speed walking
1 Light aerobic activity (e.g., normal walking, golf).

**TIME**

3 Over 30 minutes
2 30 minutes
1 Under 30 minutes

**READINESS CHECKLIST:**

**Who, if anyone, is supportive of your decision to begin weight loss efforts now?**

________________________________________________

**How important is it that you lose weight at this time?** Pick a number between 1 and 10 in which 1 = “not important” and 10 = “greatest importance.”

My number = ___________

**What are the benefits to you of weight loss?**

________________________________________________

________________________________________________

________________________________________________

**What will you have to sacrifice? What are the down sides of losing weight right now?**

________________________________________________

________________________________________________

**How confident are you that you will be able to significantly change your eating and exercising habits.** Pick a number from 1 to 10 in which 1 = “not at all confident” and 10 = “extremely confident.”

My number = ____________

**How much time daily can you devote to this effort?**

________________________________________________

**If you decide to make the choice to live healthier, which of the following, if any, would work best for you?**

_____ Increase physical activity

_____ Eat more fruits & vegetables

_____ Limit eating out / fast food

_____ Eat more whole grains / high fiber foods

_____ Reduce calories / reduce portion size

_____ Eat fewer desserts and sweet foods

_____ Watch less TV

_____ Spend less time on the computer

_____ Eat less fat / fewer fatty foods

_____ Drink fewer sugar-sweetened drinks

_____ Learn more about meal preparation

_____ Get more involved in menu planning