



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. Have your insurance card with you at your first appointment.

**Hillary’s billing is done through her NPI number - 1831162775** \*\*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 to 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

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 _____<br><i>Please list medications</i>      | Y | N | _____ |
| 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 <b>alone</b> ?        | Y | N |
| Eat when you are <b>upset</b> or <b>nervous</b> ?  | Y | N |
| Eat sweets or salty <b>snacks</b> ?                | Y | N |
| Tend to <b>binge eat</b> ?                         | Y | N |
| Eat in front of the <b>TV</b> or <b>computer</b> ? | Y | N |
| Eat meals or snacks in the <b>car</b> ?            | 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   |   |   | Y | N |

If yes, specify \_\_\_\_\_  
 q. Thyroid Y N  
 r. Menopause Y N

- \_\_\_\_\_ 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 list all vitamin and herbal products:**

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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

To any foods \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

To any medications \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**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?** \_\_\_\_\_

**Do you smoke? Y N Quantity?** \_\_\_\_\_

**If you quit, for how long?** \_\_\_\_\_

**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

**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

**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 EVERYTHING YOU ATE OR DRANK YESTERDAY, OR A USUAL DAY IF MORE TYPICAL**

| Meal              | Time | Where did you eat this? | Food/drink ( <i>include how prepared</i> ) | Amount |
|-------------------|------|-------------------------|--|--------|
| Morning Meal<br>1 |      |                         |  |        |
| Snack             |      |                         |  |        |
| Lunch             |      |                         |  |        |
| Snack             |      |                         |  |        |
| Dinner            |      |                         |  |        |
| Snack/Dessert     |      |                         |  |        |



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

**PHYSICAL ACTIVITY:**

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

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**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 drinks
- \_\_\_\_\_ Reduce calories / reduce portion size
- \_\_\_\_\_ Eat fewer desserts and sweet foods planning

- \_\_\_\_\_ Watch less TV
- \_\_\_\_\_ Spend less time on the computer
- \_\_\_\_\_ Eat less fat / fewer fatty foods
- \_\_\_\_\_ Drink fewer sugar-sweetened
- \_\_\_\_\_ Learn more about meal preparation
- \_\_\_\_\_ Get more involved in menu