P. 902.404.8034
F. 902.406.7221
dietary@coastalsportsandwellness.com

Client Information

Name: _____ Date: _____

Email: _____ DOB (D/M/Y) : _____ /_____ /_____

Address: _____

City/Province: _____ Postal Code: _____

Phone Number (H): _____ (C): _____ (W): _____

Cell Provider: (Ex. Bell) _____

Occupation: _____

Medical Doctor: _____ Last Check-Up: _____

Insurance Provider: _____

Policy Number: _____ ID Number: _____

How did you hear about Coastal Sports and Wellness? _____

Do you give permission to receive our newsletters informing you of updated information on our clinic, services, insurance and/or other useful information regarding health and wellness? YES ____ NO ____

Informed Consent

I, _____ (print name), acknowledge that the purpose of nutrition counselling is to provide education and guidance on diet, nutrition, eating behaviors and related aspects of health and wellness. Benefits of nutrition counselling may include improvements to eating and/or lifestyle habits, weight management, athletic performance, and/or general feelings of health and wellbeing. Results are individualized and may vary by appointment to appointment.

I understand that a Registered Dietitian does not diagnose medical conditions nor prescribe treatments, and should not be the sole health care provider in the case of any pre-existing medical conditions and/or concerns. I have notified the Registered Dietitian of all medical conditions, medications, supplements, allergies and intolerances. If any changes occur, I will notify the Registered Dietitian immediately.

I understand that my personal health information will only be used to provide me with the most appropriate recommendations and services. All of my information will be kept confidential and will only be made accessible to those with whom I give written consent, or as otherwise permitted or required by law.

I understand that payment is required at the time of service, and that 24 hour notice is required for cancellations. I am aware that I will be charged $30.00 for same day cancellations, or the full cost of treatment for no-show appointments.

Signature: _____ Date: _____

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Client Background

1. Gender: _____ **Height:** ____**ft** ____ **in** **Weight:** _____**lbs** **Goal Weight (if applicable):** _____**lbs**

2. Medical History (Please mark all that apply)

High Blood Pressure	□	Skin - _____	□	Diabetes Type 1/Type 2	□
Low Blood Pressure	□	Recurrent Infections	□	Smoker/Past Smoker	□
Heart Condition	□	Liver Disease	□	Acid Reflux/Heartburn	□
Stroke/CVA	□	Kidney Disease	□	Diarrhea	□
High Cholesterol	□	Gallbladder Disease	□	Constipation	□
Multiple Sclerosis	□	Arthritis/Joint Pain	□	Excessive Gas	□
Parkinson's Disease	□	Cancer - _____	□	Bloating/Discomfort	□
Osteoporosis/Osteopenia	□	Depression	□	Swelling/Edema	□
Surgery - _____	□	Anxiety	□	Fatigue	□
Thyroid Disease	□	Hormonal - _____	□	Other(s) - _____	□

3. Current Medications & Supplements: _____
_____
_____
_____

4. On a scale of 1-10 (Poor-Excellent) please rate how you feel in the following wellness categories. Place 'U' beside any of the categories you are not sure about or 'NA' if you feel it does not apply:

Self-control		Work-life Balance		Mentally	
Relationships		Financially		Spiritually	
Support		Physically		Sleep	
Environment		Nutritionally		Energy	

5. Activity Level: Sedentary ___ Low Activity ___ Moderate Activity ___ High Activity ___ Extremely Active ___

6. Types & frequency of physical activity:

7. Food Allergies & Intolerances & Sensitivities:

8. Food Avoidances & Dislikes:

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9. Have you tried any special eating patterns, diets or nutrition programs in the past?

10. What is/are your current reason(s) for seeking nutrition counselling?

Weight Loss/Gain	□	Sport Nutrition	□	Meal Planning	□
Disease Management	□	General Nutrition	□	Family Nutrition	□
Disease Prevention	□	Wellness Coaching	□	Nutrient Deficiencies	□
Special Diet	□	Education	□	Other - _____	□

11. Briefly describe your goals and why you are interested in investing in your nutrition, health & wellness:
For example, I would like to improve my diet so that I have more energy to play with my kids!

12. What do you feel are your biggest challenges to making changes in your diet and/or lifestyle right now?

13. Have you seen a Dietitian or Nutritionist before? If so, please indicate their name and location:

14. Please mark your other forms of health treatment:

	PAST	CURRENT		PAST	CURRENT
Physiotherapy	□	□	Osteopathy	□	□
Chiropractic	□	□	Massage	□	□
Naturopathy	□	□	Other - _____	□	□

15. Please state any questions or concerns you may have:

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3 Day Record of Food & Beverage Intake

Please follow your usual habits, include everything, and be as detailed as possible with times and amounts!

Day 1:	Day 2:	Day 3:

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Electronic Transmission Authorization and Consent & Benefit Assignment Form

This form must be filled out when claims are submitted electronically by the provider on the patient's behalf. Please retain this form in the patient's file for verification purposes for two years following the closure of the patient file.

PLEASE CHECK YOUR LOCATION:

- O 15 Dartmouth Rd, Suite 200
  Bedford, NS B4A 3X6
  902-404-8034
- O Mount Saint Vincent University – Assisi Bldg., 2nd Floor
  Halifax, NS B3M 2J6
  902-404-8034

Patient: _____

Consent to Collect and Exchange Personal Information

Message to the Plan member, Spouse, and/or Dependant regarding Personal information
Personal information that we collect and disclose about you, and if applicable, your spouse and/or dependants, is used by the insurer and/or plan administrator and they service provider(s) for the purposes of assessing your claims, underwriting, investigating, auditing and administering the group benefits plan, including the investigation of fraud and/or plan abuse.

Authorization and Consent
I authorize my healthcare provider to collect, use and disclose personal information concerning any claims submitted on my behalf with the insurer and/or plan administrator and their service provider(s) for the above purposes.

I authorize the insurer and/or plan administrator and their service provider(s) to:

- Use my personal information for the above purposes
- Exchange personal information with any individual or organization, including healthcare professionals, investigative agencies, insurers and reinsurers, and administrators of government benefits or other benefits programs when relevant for the above purposes
- Exchange personal information concerning any claims submitted with the plan member or a person acting on behalf of the plan member
- Exchange personal information for the above purposes electronically or in any other manner

I understand that personal information may be subject to disclosure to those authorized under applicable law.

I agree that a photocopy or electronic version of this authorization shall be as valid as the original, and may remain in effect for the continued administration of the group benefits plan.

Additional Consent Applicable to Plan Members Only
I confirm that I am authorized by my spouse and/or dependents, if any, to disclose personal information about them to the insurer and/or plan administrator and their service provider(s) for the purposes described above and I confirm that my spouse and/or dependents also authorize the insurer and/or plan administrator and their service provider(s) to disclose information about their claims to me, for the purposes of assessing and paying a benefit, if any, and managing the group benefits plan. I also authorize my spouse and/or dependents to assign benefit payments under the plan to the healthcare provider.

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In the event there is suspicion and/or evidence of fraud and/or plan abuse concerning claims submitted, I acknowledge and agree that the insurer and/or plan administrator and their service provider(s) may use and disclose relevant personal information to any relevant organization including law enforcement bodies, regulatory bodies, government organizations, medical suppliers and other insurers, and where applicable, my Plan Sponsor, for the purposes of investigation and prevention of fraud and/or plan abuse.

If there is an overpayment, I authorize the recovery of the full amount of the overpayment from any amount payable under the group benefits plan, and the exchange of personal information with other persons or organizations, including credit agencies and, where applicable, my Plan Sponsor, for that purpose.

Benefit Assignment

I hereby assign benefits payable for the eligible claims to the Provider responsible for submitting my claims electronically to the group benefits plan and I authorize the insurer/plan administrator to issue payment directly to the Provider. In the event my claim(s) are declined by the insurer/plan administrator, I understand that I remain responsible for payment to the Provider for any services rendered and/ or supplies provided.

I acknowledge and agree that the insurer/plan administrator is under no obligation to accept this Assignment, that any benefit payment made in accordance with this Assignment will discharge the insurer/plan administrator of its obligations with respect to that benefit payment, and that in the event the benefit payment is made to me, the insurer/plan administrator will also be discharged of its obligation with respect to that benefit payment.

I understand that this Assignment will apply to all eligible claims submitted electronically by the Provider and that I may revoke it at any time by providing written notice to the insurer/plan administrator.

If I am a spouse or dependent, I confirm that I am authorized by the plan member to execute an assignment of benefit payments to the Provider.

_____ _____

Date Signature

_____

Print Name

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Credit Card Information

We now require a credit card on file for all clients at Coastal Sports and Wellness Inc. with insurance companies that require a paper claim to be submitted for reimbursement.
For a full list of insurance companies this includes, see the front desk.

All clients will be notified via email or phone in the event that your card is being charged.

Name on Card _____

Credit Card Number _____

Expiration Date _____ /_____ CVV Code _____
Month Year (3 digits on back of card)

Informed Consent

I, _____(client), acknowledge that I am willingly providing my correct credit card information to Coastal Sports and Wellness Inc., for use only in cases where:

a) Online direct billing submission covers less than anticipated amount and other payment type is not arranged within one week of being notified by clinic of insurance issue(s).
b) Payment is not provided upon leaving the clinic
c) 24 hour cancellation policy not met (Full price of service will be charged)

I understand that I will be required to provide this information in order to continue treatments at Coastal Sports and Wellness Inc., and that this form is to be updated annually.

I understand that Coastal Sports and Wellness Inc. will only use my credit card information for reasons stated above with proper notification (via email or phone) prior to use by clinic.

Signature: _____ Date: _____
(if child under 18, legal guardian must sign)