



Joy Supplee, MS, RD, CD, CLT Offices on Mercer Island and in Maple Valley

206-295-6810 joy@customfitnutrition.net

Client Intake Form

Below you will find a lot of detailed information regarding your rights and responsibilities and established policies of Joy Supplee, Custom Fit Nutrition, LLC. Please read this carefully and sign at the bottom.

Appointments

I agree to make every effort to keep all schedule appointments and be on time. If I cannot attend a scheduled session, I will call to cancel and/or reschedule. There will be no fee if phone message or conversation is received before 24 hours of the scheduled appointment time. If phone message or conversation is received after the 24 hour time frame a fee will be charged for that cancelled or missed session. (Please note that if insurance is being used for payment, insurance cannot be billed for a no-show/late cancellation and therefore the client is responsible for the fee).

Initial appointments will last at least 60 minutes. Follow up appointments can be either 30 or 60 minutes, according to my preference.

I have been informed that Joy Supplee, Custom Fit Nutrition, LLC has the right to terminate services offered with a 30 day written notification given to the client with a listing of referrals for continuity of care.

Confidentiality

I understand that no information about my treatment will be released to anyone unless I provide written authorization. The only exception to this would be if I have not paid for services and are sent to collections for payment; then necessary information will be released in order for payment of service. I also understand that there are limits to my confidentiality, including the following:

- Where there is the risk of imminent harm to myself or another person, Joy Supplee, Custom Fit Nutrition, LLC has the legal and/or ethical duty to take the appropriate steps to protect life.
- When a court orders release of information, Joy Supplee, Custom Fit Nutrition, LLC is bound by law to comply.
- When there is reason to believe that a child or an elderly person is in danger of or is being abused (physically, emotionally, or sexually), Joy Supplee, Custom Fit Nutrition, LLC is obligated by law to report the abuse.
- In response to a subpoena from a court of a law or a secretary

Email

I understand that email may not be a confidential method of communication and understand that phone or in-person contact is the best way to communicate personal information. I also understand that there are instances where e-mails are sent but never received. For these reasons, phone or in-session contact is the preferred method to ensure a timely response. I also understand that Joy Supplee, Custom Fit Nutrition, LLC will not offer nutrition counseling over email, but rather uses email communication mainly for scheduling purposes.

Fees and Financial Agreement

Custom Fit Nutrition, LLC: 60 minute initial assessment session = \$150.00

60 minute follow-up session = \$135.00 30 minute follow-up session = \$65.00

Fees for service are due at the time the service is provided. Cancellation policy is outlined above.

Forms of payment accepted include: cash, check, major credit card or debit card. A discount will be offered for paying in cash or check at the time of the visit.



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If you have insurance, Joy Supplee, Custom Fit Nutrition, LLC will bill the insurance company directly. Please provide your insurance card for copying and complete the insurance information on the attached page. I will be responsible for payment of any remainder due that my insurance does not cover. I will also be responsible to pay my copay amount, if any, at the time of service.

Appointments and Cancellations

I agree to make every effort to keep all schedule appointments and be on time. If I cannot attend a scheduled session, I will call to cancel and/or reschedule. There will be no fee if phone message or conversation is received before 24 hours of the scheduled appointment time. If phone message or conversation is received after the 24 hour time frame a \$50 fee will be charged for that cancelled or missed session. (Please note that if insurance is being used for payment, insurance cannot be billed for a no-show/late cancellation and therefore the client is responsible for the fee.)

Signature: _____ Date: _____
Printed Name: _____ Date: _____

Counseling Process and Your Rights Regarding Treatment

I understand that Joy and I will work together to define my goals for nutrition counseling. Since nutrition counseling is not an exact science, I understand that the results of counseling can be variable. I understand that the attainment of a positive outcome is dependent upon the effort expended by both myself and Joy and I am willing to put my part into this experience.

I understand that I have the right to ask questions about my counseling. I have a right to choose a Dietitian who best suits my needs and purposes. I also have the right to end my counseling at any time and understand that I should notify Joy when I am finished. If I decide that I would like to continue my nutrition counseling with another professional, Joy Supplee can facilitate that process. I understand that Joy reserves the right to refer me to another professional if the level of care provided by Joy is assessed by Joy to not be the appropriate level of care.

Washington State Law

I understand that if I have concerns about my treatment I can talk directly with Joy about these issues. I also understand that if I want more information about the law regulating counselors or want to file a complaint I can write to: Department of Health, Health Professions Quality Assurance, PO Box 47869, Olympia, Washington, 98504 or call (360) 236-4700. I have been given Joy Supplee’s disclosure statement.

Consent for Treatment

I have read through all the previous information and have been clearly advised of my rights and responsibilities as a client of Joy Supplee, Custom Fit Nutrition, LLC. I understand these rights and responsibilities and agree to abide by them. I consent to treatment, and I understand I have a right to receive a copy of this form upon request. I also understand that I can withdraw this consent in writing and terminate at any time.

Client Name (please print) _____

Signature _____ Date _____

Parent Signature if Patient Under 18 _____ Date _____



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| Name: | | Date of Birth: | |
|---|-------------------------|--------------------------|--|
| Address: | | | Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female |
| City: | State: | Marital Status: | |
| Home Number: | Work Number: | Zip: | |
| Employer: | Insurance Provider: | Insurance Phone Number: | |
| Insurance ID Number: | Email Address: | | |
| List Your Main Health Complaints (In order of importance) | | | Duration of Problem |
| 1. | | | |
| 2. | | | |
| 3. | | | |
| 4. | | | |
| Surgical History (Please list all surgeries) | | | |
| 1. | 2. | | 3. |
| Circle (Or Write In) All Medical Conditions You Have Been Previously Diagnosed With | | | |
| Arthritis, Rheumatoid | Crohn's Disease | Hypoglycemia | Fructose Intolerance |
| Arthritis, Osteo | Depression | Interstitial Cystitis | Other: |
| Asthma | Diabetes | Irritable Bowel Syndrome | Other: |
| Attention Deficit Disorder | Eczema | Lactose Intolerance | Other: |
| Celiac Disease | Gastroesophageal Reflux | Migraine | Other: |
| Chronic Fatigue Syndrome | Hives | Rhinitis | Other: |
| Colitis | Hypertension | Ulcerative Colitis | Other: |
| List All Medications You Currently Take Regularly OR As Needed (Prescription & OTC) | | | |
| Drug | Dosage | # Times Per Day | Start Date |
| | | | |
| | | | |
| | | | |



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| Allergy History | |
|--|---|
| Does Anyone In Your Family Have Allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| If Yes: <input type="checkbox"/> Parent <input type="checkbox"/> Sibling <input type="checkbox"/> Other Blood Relative: | |
| If Yes, What Are They Allergic To? <input type="checkbox"/> Food <input type="checkbox"/> Medication <input type="checkbox"/> Pollen <input type="checkbox"/> Dust <input type="checkbox"/> Other: | |
| Do you Have Any Known Allergies? <input type="checkbox"/> Yes <input type="checkbox"/> No | |
| List All Foods, Additives, and Medications That You <u>KNOW OR SUSPECT</u> You Are Allergic To: | |
| | |
| List All Vitamins & Herbs Taken On A Regular Basis | |
| | |
| | |
| | |
| | |
| | |
| Diet History | |
| # of times you typically skip Breakfast each week: | How many snacks do you typically eat per day? |
| # of times you typically skip Lunch each week: | Circle below all snacks you typically eat |
| # of times you typically skip Dinner each week: | Chips Cookies Candy Fruit Veggies Other |
| Place a letter next to each beverage indicating how often you consume it using the following scale: D = Daily, W = Weekly, M = Monthly 0 = Never or almost never. | |
| ___ Water ___ Coffee ___ Tea ___ Soda ___ Milk ___ Juice ___ Wine ___ Beer ___ Other: | |
| How many times do you typically eat out each week? | |
| How many times per week do you eat at a "Fast Food" restaurant? | |