Jennifer McGurk, RDN, CDN, CDE, CEDRD
Elyssa Toomey, RDN, RYT
99 Main Street, Suite 204 - Nyack, NY 10960 - 845-535-9092

Client Assessment Form

Thank you so much for your interest in nutrition counseling from Eat With Knowledge. Please fill out this form to collect important information before the first appointment. If you are under 18 years old, please fill this out with the help of a parent.

Personal Information:

Name: _____

Birthday: _____

Age: _____

Occupation: _____

Place of employment: _____

Home Phone Number: _____ May I leave a message? ____

Cell Phone Number: _____ May I leave a message? ____ Text? ____

Email: _____ May I add you to my newsletter? _____

Address: _____

City, State, Zip: _____

If under 18:
Parent/Guardian(s) Name: _____ Please provide phone #/address/email

How did you hear about Eat With Knowledge? Who referred you?

Medical Information:

Past medical history: _____

_____

Current medications and dosages (please include supplements):

_____

_____

Height: _____

Weight: _____

Eating habits:

Tell me about your nutrition goals: _____

_____

Please tell me about a typical day in your general diet:

How many times per week do you eat out? _____

What restaurants do you go to? _____

How often do you snack? _____

What do you snack on? _____

Exercise habits:

What do you do for physical activity? _____ How often? _____

Do you have any physical conditions that prevent you from exercising? _____

Do you have any exercise goals? _____

What are your expectations for today's session and long-term: _____

_____

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Authorization for Release of Information

I authorize Eat With Knowledge to release my protected private medical and health information to the below providers concerning my coordination of care. I understand I can revoke this authorization at any time by providing *written* notice to Eat With Knowledge.

I authorize Jennifer McGurk, RDN and Elyssa Toomey, RDN

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to exchange records (provide and receive information) with each other in supervision as well as:

Therapist: _____
Name of receiving person, agency or institution
Phone Email

Primary Care Physician: _____
Name of receiving person, agency or institution
Phone Email

Specialty Physician: _____
Name of receiving person, agency or institution
Phone Email

Other: _____
Name of receiving person, agency or institution
Phone Email

_____ _____
Client- Please *sign* and print Date

_____ _____
Parent/Guardian- Please *sign* and print Date

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Office Policy Information- Updated December 2017

Confidentiality:
All information disclosed within sessions is confidential. If we see you outside the office (ex. Grocery store, restaurant, etc.) we will respect your privacy and will NOT initiate a conversation. We will exchange information with your team of professionals ONLY by signing the Authorization to Release Information form.

Payment:
Payment is expected in full by cash, credit card, or check on the day of the appointment. Rates:
Initial appointment (60 minutes): $250, follow-up (45 minutes): $160, follow up (30 minutes): $120
Please note that fees increase every year (in January). Clients will always be given at least one month notice.

Medical Insurance:
Insurance companies may or may not cover medical nutrition therapy. Eat With Knowledge does not accept insurance payment for sessions. Carefully investigate the "out of network" coverage you have.

Cancellations:
We value and respect your time as a client of Eat With Knowledge. We ask you to do the same in return. A credit card is required to hold appointments. **A 48 hour notice is required to cancel or reschedule an appointment.** You can always have a phone session if you cannot get into the office. You will be charged for the appointment if you do not give 48 hours notice, or do not show up for the appointment. Please note that all cancelations and rescheduling for appointments is preferred **by phone, not emails or texts**. We respectfully ask that final termination sessions happen in person and not over the phone or email.
WEATHER CANCELLATIONS: We will close the office if local schools are closed and reschedule appointments.

Name on Card	
Card Number	
Expiration Date	
Card Security Code (3-digit # on back)	
Billing Address Zip Code	

I have read and understand the above information. I agree to authorize Eat With Knowledge to collect a fee from my credit card account based on the information provided above. No refunds are given under any circumstances. Please keep a copy for your records.

_____ _____
Client- Please *sign* and print Date

_____ _____
Parent/Guardian- Please *sign* and print Date