

PATIENT REGISTRATION

(Please print clearly)

Patient Name: First			Middle			Last			Home Phone Number:	
Home Address:				Apt. No.		City:			State	Zip Code:
Occupation:		Marital Status			Date of Birth			Age:	Gender:	
E-mail address:					Cell Phone:					
Employer:			Address:				Work Phone Number:			
Spouse (or parent) name:										
Spouse (or parent) employer:						Work Phone Number:				
Family Physician:			Address:				Phone:			
Referred By:			Address:				Phone:			

BILLING AND INSURANCE INFORMATION

PRIMARY INSURANCE	Insurance Company Name:			ID or Policy Number:			Group / Code		
	Subscriber's Name:			Date Effective:					
	Subscriber's Date of Birth:			Sex:	Home Phone Number:			Relationship to Patient:	

Do you have any other Insurance? Yes No (If yes, please specify)

A message: can can not be left on my home phone. (Please check a box.)

PRIVACY CONSENT

Rebecca Bitzer MS RD & Associates (RBA) requires your consent to use and disclose your protected health information to carry out treatment, payment and healthcare operations. If you would like a more detailed description of such uses and disclosures please refer to our Notice of Privacy Practices. You have the right to review our Notice of Privacy Practices before signing this Consent. The terms of our Notice of Privacy Practices of RBA may change from time to time. You can get a copy of our revised Notice of Privacy Practices by contacting our office at 301-474-2499. We will also post a copy of our current Notice of Privacy Practices in our office.

You have the right to revoke this consent in writing and the revocation will be effective except to the extent RBA has acted in reliance on your consent.

I have had an opportunity to discuss with the Registered Dietitian and/or with other office personnel, the nature and purpose of medical nutrition therapy. I understand the results are not guaranteed. I give RBA permission to send a summary note to my physician or referring doctor of my consultation here.

By signing below, you hereby consent to our use of your protected health information for treatment, payment and health care operations and acknowledge receipt of a copy of this Consent if requested.

Printed Name: _____

Signature: _____ **Date:** _____

POLICIES

1. I hereby authorize Rebecca Bitzer MS RD & Associates (RBA) to apply for benefits on my behalf for covered services rendered by RBA and request that payments be made directly to RBA. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims.
2. I understand that RBA may bill me for services rendered, if my insurance company or Medicare fails to assign payment to RBA despite prior approval of services. I agree to be fully and personally responsible for payment. RBA agrees to refund me any duplicate payments.
3. **Cancellation Policy:** We have a fixed and moderate patient load so that we can provide the best quality of care for you. **We strive to see you on time because we value your time as well as ours.** When you have a scheduled appointment, that time is reserved solely for you. If you cancel an appointment, you must do so at least 24 hours in advance. If you cancel less than 24 hours, you will be **charged \$50** for your missed appointment. Please call as soon as possible to schedule a make-up appointment during the same week if space exists, to avoid the fee.

I understand that if I have pre-paid fees for follow-up appointments or packages, these fees will not be refunded or exchanged and my appointment will be forfeited if I do not show or if I cancel my appointment with less than 24 hours notice.

FEES:

◆ **Charge for missed appointments - \$50.00**

These cancellation charges are **not** reimbursable by your insurance company.

◆ I understand **copays are due at the time of the appointment.**

◆ I understand there is a **\$25 fee for any returned checks. All payments for a returned check and further payments will be due in cash or money order only.**

◆ I understand there **is a \$25 fee for any account sent to collections.**

4. **I have read, understand, received a copy (if requested) and agree to these policies.**

Signature: _____ Date: _____

NUTRITION ASSESSMENT

Reason for today's visit: _____

1. Have you ever worked with a dietitian/nutritionist? Yes ____ No____ If yes, who:

2. List any medications that you are currently taking and their uses:

3. List any herbal and/or vitamin/mineral supplements you are taking:

4. Are you currently engaged in a regular exercise program? Yes ____ No ____

Please describe: _____

5. Any symptoms of nausea vomiting diarrhea constipation (circle any or all that apply)

6. What was your highest adult weight? _____

7. What was your lowest adult weight? _____

8. What is your height? _____

9. Is there any family medical history that we should be aware of:

10. Do you smoke cigarettes?_____

11. Do you experience mood swings, nervousness, or mental tension (please circle)?

12. Is there any other medical information concerning you that we should be aware of:

13. List any goals you hope to achieve as a result of nutrition counseling:

14. List your hobbies, television habits, and reading habits

15. Please add any other comments that you would like us to know:

FOOD QUESTIONNAIRE

Food Likes: _____

Food Dislikes: _____

Eating Out: How many times per week do you eat the following meals out?

Breakfast: _____ Lunch: _____ Dinner: _____

Which Restaurants: _____

How many times a day do you eat foods in the following categories?

1. Fruits: _____
2. Vegetables: _____
3. Bread/Cereals/Rice/Pasta: _____
4. Nuts or Beans: _____
5. Red Meat: _____
6. Chicken and Turkey: _____
7. Fish: _____
8. Tofu/Soy: _____
9. Dairy Foods (Milk, Yogurt, Cheese): _____
10. Chips, Crackers, Pretzels: _____
11. Sweets: _____
12. Sodas: _____ Juices: _____
13. Beer, Wine, Mixed Drinks: _____
14. Water: _____

Please record what you eat and drink on a "typical day"

	Time	Food eaten (Describe)
Breakfast		
Lunch		
Dinner		
Snacks		