

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

Thank you for choosing Rebecca Bitzer MS, RD & Associates (RBA) as your nutrition specialist. The following rules will help facilitate a positive working relationship.

1. I hereby authorize RBA to apply for benefits on my behalf for covered services rendered. I certify that all information given is correct, and authorize the release of all information, including medical information, for this or related claims.
2. I understand RBA may bill me for services rendered upon denial of my insurance company/ Medicare—despite prior approval. I agree to be fully and personally responsible for payment.

Policies to Know:

- ◆ It is your responsibility to obtain the proper referral prior to your visit and bring it with you. If a referral is faxed, please call to verify that it was received. Please do not ask us to get your referral. **If your insurance requires a referral, you will not be seen by a dietitian without a referral unless you self-pay the fee for the entire visit (\$200 for initial visit, \$100 for follow-up appointment) upfront.** We will not submit this date of service to insurance; therefore, no refund will be given.
 - ◆ Co-pays are due at the beginning of the appointment. **We do not bill for co-pays.**
 - ◆ We require **24 hour notice** to cancel and/or change appointments or a **\$30 fee** will be issued.
 - ◆ 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.**
 - ◆ If your account is 90 days past due, it will be sent to a collection agency. A **\$25 collections fee** will be issued.
3. All clients need to handle any bills in a timely fashion. You will NOT be seen by your Dietitian if you have an outstanding balance.
 4. We allow 45 days for your insurance company to make payment to us. Sometimes insurance companies request more information before they make a payment; please respond promptly to your insurance company or RBA with requests for further information. If you fail to respond, you will be billed and expected to pay promptly.
 5. Each insurance has different guidelines as to what diagnoses are covered. We strive to stay current with all insurance coverage guidelines, but we cannot guarantee any coverage.

Thank you for your cooperation!

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

Signature: _____ **Date:** _____

Symptom Survey

Date: _____

In order to provide our patients with the best possible care, please fill in the following form completely. Score every symptom based on your experience over the last 30 days, or since your last Symptom Survey, whichever was most recent. Using the SCALE OF SYMPTOM POINTS listed below, FILL IN the appropriate score in the corresponding field for **every symptom** listed. Total the points for each category and add all category totals to come up with the Grand Total.

SCALE OF SYMPTOM POINTS:

- = 0 = Suffer From This Never or Almost Never
- = 1 = Suffer OCCASSIONALLY (less than 2 times per week), symptom **isn't severe**
- = 2 = Suffer FREQUENTLY (2 or more times per week), symptom **isn't severe**
- = 3 = Suffer OCCASSIONALLY and symptom **is severe**
- = 4 = Suffer FREQUENTLY and symptom **is severe**

Grand Total:

CONSTITUTIONAL

- Fatigue (sluggish, tired)
- Hyperactive (nervous energy)
- Restless (can't relax/sit still)
- Sleepiness During Day
- Insomnia at Night
- Malaise (Feeling Lousy)
- _____ TOTAL (0-24)

EMOTIONAL/MENTAL

- Depression
- Anxiety
- Mood Swings
- Irritability
- Forgetfulness
- Lack of concentration/focus
- _____ TOTAL (0-24)

HEAD/EARS

- Headache (any kind)
- Earache
- Ear Infection
- Ringing in Ears
- Itchy Ears
- Discharge From Ears
- _____ TOTAL (0-28)

SKIN

- Blemishes, Acne
- Rashes, Hives
- Eczema
- "Rosy" Cheeks
- _____ TOTAL (0-16)

NASAL/SINUS

- Post Nasal Drip
- Sinus Pain
- Runny Nose
- Stuffy Nose
- Sneezing
- _____ TOTAL (0-20)

MOUTH/THROAT

- Sore Throat
- Swollen Throat
- Swelling of Lips/Tongue
- Gagging/Throat Clearing
- Canker Sores
- _____ TOTAL (0-20)

LUNGS

- Wheezing
- Chest Congestion
- Dry Cough
- Wet Cough
- _____ TOTAL (0-16)

EYES

- Red or Swollen Eyes
- Watery Eyes
- Itchy Eyes
- Dark Circles or "Bags"
- _____ TOTAL (0-16)

GENITOURINARY

- Increased Urination Frequency
- Painful Urination
- _____ TOTAL (0-8)

MUSCULOSKELETAL

- Joint Pain/Aching
- Stiff Joints
- Muscle Aches
- Stiff Muscles
- _____ TOTAL (0-16)

CARDIOVASCULAR

- Irregular Heartbeat
- High Blood Pressure
- _____ TOTAL (0-8)

DIGESTIVE

- Heartburn/Reflux
- Stomach Pains/Cramps
- Intestinal Pains/Cramps
- Constipation
- Diarrhea
- Bloating Sensation
- Gas (of Any Kind)
- Nausea, Vomiting
- Painful Elimination
- _____ TOTAL (0-36)

WEIGHT MANAGEMENT

- _____ **Record Actual Weight**
- Fluctuating Weight
- Food Cravings
- Water Retention
- Binge Eating or Drinking
- Purging (all methods)
- _____ TOTAL (0-20)

Health History

List Your Main Health Concerns (In order of importance)	Duration of Problem
1.	
2.	
3.	
4.	

Please list all surgeries

1.	2.	3.
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Circle (Or Write In) All Medical Conditions Previously Diagnosed

Arthritis, Rheumatoid	Crohn's Disease	Hypoglycemia	Fructose Intolerance
Arthritis, Osteo	Depression	Interstitial Cystitis	High Cholesterol:
Asthma	Diabetes	Irritable Bowel Syndrome	Food Allergies:
Attention Deficit Disorder	Eczema	Lactose Intolerance	Other:
Celiac Disease	Gastroesophageal Reflux	Migraine	Other:
Chronic Fatigue Syndrome	Hives	Rhinitis	Other:
Colitis	High Blood Pressure	Ulcerative Colitis	Other:

List All Medications And Supplement You Currently Take Regularly OR As Needed (Prescription & OTC)

Drug	Dosage	# Times Per Day	Start Date

List any family medical history that we should be aware of:

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

NUTRITION ASSESSMENT

Reason for today's visit:

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

Height:	Weight:	What was your highest adult weight?	What was your lowest adult weight?
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Have you ever worked with a dietitian/nutritionist? Yes _____ No _____ If yes, who: _____

Are you currently engaged in a regular exercise program? Yes _____ No _____ How often? _____

If yes, please describe:

Do you cook? Yes _____ No _____

List your hobbies, television habits, and reading habits

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

FOOD QUESTIONNAIRE

What are your favorite foods?

What are your least favorite foods?

How many times **PER WEEK** do you eat the following meals **out**?
(fast food, take out, restaurants) Breakfast: _____ Lunch: _____ Dinner: _____

Which Restaurants?

How many times in **PER DAY** do you eat foods from the following categories?

Fruit: _____ Vegetables: _____ Bread/Cereals/Rice/Pasta: _____ Nuts or Beans: _____

Red Meat: _____ Chicken and Turkey: _____ Fish: _____ Tofu/Soy: _____ Sweets: _____

Dairy (Milk, Yogurt, Cheese): _____ Chips, Crackers, Pretzels: _____ Soda: _____ Juice: _____

Beer, Wine, Mixed Drinks: _____ Water: _____ Sweetened Beverages (Juice, Tea, Sports Drinks): _____

Please record what you eat and drink on a "typical day"		<i>Location (kitchen, car, work, bedroom, living room, etc)</i>
<i>Time</i>	<i>Food eaten (Describe)</i>	
<i>Breakfast</i>		
<i>Lunch</i>		
<i>Dinner</i>		
<i>Snacks</i>		