

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) for your wellness goals. Your understanding of the following policies will help facilitate a positive working relationship.

Policies to Know:

1. It is my responsibility to obtain a proper referral prior to my visit and bring it with me. If a referral is faxed, I will call to verify that it was received. If my insurance company requires a referral, the dietitian will not see me without one unless I self-pay the fee for the entire visit (\$200 for initial visit, \$100 for follow-up appointment) upfront. The date of service will not be submitted to insurance; therefore, no refund will be given.
2. My co-pay is due before my appointment. I may not ask RBA to bill me for my co-pay.
3. If I fail to provide 24-hour notice to cancel and/or change my appointment, I will be billed a \$60 fee, which must be paid before my next appointment.
4. I will be billed a \$25 fee for any returned check. All payments for a returned check and further payments will be due in cash or money order only.
5. If my account is 90 days past due, it will be sent to a collection agency and I will be responsible for a \$25 collections fee.

Insurance Policies to Know:

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 that RBA allows 45 days for my insurance company to make payment. If my insurance company requests more information, I will respond promptly to my insurance company or RBA with that information. If I fail to respond with that information after 7 days, I will be billed for the rendered services.
3. I understand that RBA will not respond to secondary requests for additional information from my insurance company. Upon receipt of such requests, I will be responsible for paying RBA for the services rendered.
4. I understand RBA will submit one appeal for a claim denied by my insurance company. When my insurance company denies a claim twice, I will be responsible for paying RBA for the services rendered.
5. I understand that my insurance company does not guarantee coverage of Medical Nutrition Therapy and that I will be responsible for all non-covered services rendered.
6. I understand that all bills must be paid in a timely fashion. If I still have an outstanding balance when I arrive for my scheduled appointment, the dietitian will not see me.

Self-Pay Policies to Know:

1. I understand that a Self-Pay Package must be paid in full at my first appointment.
2. I understand that a Self-Pay Package offers visits at a discounted rate; therefore, these visits cannot be submitted to my insurance company by RBA.
3. I understand that I can submit the visits to my insurance company for personal reimbursement, but that my insurance company may not reimburse me at all.
4. I understand that reimbursement should be sent to me. If my insurance company reimburses RBA for the visits, the check will be voided and sent back with an explanatory letter.
5. I understand that my insurance company may not reimburse me in full for the package; RBA will not reimburse the difference.

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

Signature: _____ **Date:** _____

| 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. |

| Circle (Or Write In) All Medical Conditions Previously Diagnosed | | | |
|------------------------------------------------------------------|-------------------------|--------------------------|--------------------|
| Arthritis | Depression | High Cholesterol | Migraine |
| Asthma | Diabetes | Hypoglycemia | Food Allergies |
| Attention Deficit Disorder | Eczema/skin diagnosis | PCOS | Ulcerative Colitis |
| Celiac Disease | Gastroesophageal Reflux | Irritable Bowel Syndrome | Epilepsy |
| Crohn's Disease | High Blood Pressure | Lactose Intolerance | Other: |
| Lupus | Infertility | Sleep Apnea | Other: |

| List All Medications 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: | | | |
| List all vitamins, minerals, and/or supplements: | | | |
| Are you interesting in any of the following? Please circle: | | | |
| Blood Pressure Testing | Medical Weight Loss | Body Fat Testing | Vitamin and Mineral Deficiency Testing |
| Gene Snip Analysis | Metabolism Testing | Measurements | Glucose Meter Testing Training |

NUTRITION ASSESSMENT

Reason for today's visit:

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

Height: _____ Weight: _____ Do you consider yourself: ___Underweight ___Overweight ___ Just right

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 per day do you eat from the Following:

| | | | |
|---------------------------|--|----------------------------|--|
| Fruit | | Sweets | |
| Vegetables | | Dairy (milk/yogurt/cheese) | |
| Breads/Cereals/Rice/Pasta | | Chips/Pretzels/Crackers | |
| Nuts/beans | | Soda | |
| Red Meat | | Juice | |
| Chicken/Turkey | | Beer/Wine/Mixed Drinks | |
| Fish | | Water | |
| Tofu/soy | | Sweetened Beverages | |

| Please record what you ate and drank yesterday | | | <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> | | | |

What are you looking for? Check all that apply:

| Energy- Vitality | Longevity-Life Enrichment | Body Composition | Stress Reduction |
|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <input type="checkbox"/> Have more energy <input type="checkbox"/> Have longer endurance <input type="checkbox"/> Have more motivation <input type="checkbox"/> Sleep better <input type="checkbox"/> Be less tired after lunch <input type="checkbox"/> Feel more vital <input type="checkbox"/> Get less colds and flu <input type="checkbox"/> Get rid of my allergies <input type="checkbox"/> Decrease OTC drugs <input type="checkbox"/> Stop using laxatives <input type="checkbox"/> Be free of pain | <input type="checkbox"/> Reduce risk of disease <input type="checkbox"/> Slow down aging <input type="checkbox"/> Monitor markers of aging <input type="checkbox"/> Have less facial wrinkles <input type="checkbox"/> Maintain a healthier life <input type="checkbox"/> Create wellness lifestyle | <input type="checkbox"/> Be stronger <input type="checkbox"/> Be thinner <input type="checkbox"/> Be more Muscular <input type="checkbox"/> Burn more body fat <input type="checkbox"/> Be more flexible <input type="checkbox"/> Lose weight | <input type="checkbox"/> Be happier <input type="checkbox"/> Be less depressed <input type="checkbox"/> Be less moody <input type="checkbox"/> Be less indecisive <input type="checkbox"/> Be more focused <input type="checkbox"/> Think more clearly <input type="checkbox"/> Improve memory <input type="checkbox"/> Reduce stress |

Symptom Survey

Please check all that apply:

| | | |
|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| <p>CONSTITUTIONAL</p> <input type="checkbox"/> Fatigue (sluggish, tired) <input type="checkbox"/> Hyperactive (nervous energy) <input type="checkbox"/> Restless (can't relax/sit still) <input type="checkbox"/> Sleepiness During Day <input type="checkbox"/> Insomnia at Night <input type="checkbox"/> Malaise (Feeling Lousy) <p>EMOTIONAL/MENTAL</p> <input type="checkbox"/> Depression <input type="checkbox"/> Anxiety <input type="checkbox"/> Mood Swings <input type="checkbox"/> Irritability <input type="checkbox"/> Forgetfulness <input type="checkbox"/> Lack of concentration/focus <p>MUSCULOSKELETAL</p> <input type="checkbox"/> Joint Pain/Aching <input type="checkbox"/> Stiff Joints <input type="checkbox"/> Muscle Aches <input type="checkbox"/> Stiff Muscles | <p>HEAD/EARS</p> <input type="checkbox"/> Headache (any kind) <input type="checkbox"/> Earache <input type="checkbox"/> Ear Infection <input type="checkbox"/> Ringing in Ears <input type="checkbox"/> Itchy Ears <input type="checkbox"/> Discharge From Ears <p>NASAL/SINUS</p> <input type="checkbox"/> Post Nasal Drip <input type="checkbox"/> Sinus Pain <input type="checkbox"/> Runny Nose <input type="checkbox"/> Stuffy Nose <input type="checkbox"/> Sneezing <p>WEIGHT MANAGEMENT</p> <input type="checkbox"/> Fluctuating Weight <input type="checkbox"/> Food Cravings <input type="checkbox"/> Water Retention <input type="checkbox"/> Binge Eating or Drinking <input type="checkbox"/> Purging (all methods) | <p>DIGESTIVE</p> <input type="checkbox"/> Heartburn/Reflux <input type="checkbox"/> Stomach Pains/Cramps <input type="checkbox"/> Intestinal Pains/Cramps <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Bloating Sensation <input type="checkbox"/> Gas (of Any Kind) <input type="checkbox"/> Nausea, Vomiting <input type="checkbox"/> Painful Elimination <p>LUNGS</p> <input type="checkbox"/> Wheezing <input type="checkbox"/> Chest Congestion <input type="checkbox"/> Cough <p>GENITOURINARY</p> <input type="checkbox"/> Increased Urination Frequency <input type="checkbox"/> Painful Urination <p>MOUTH/THROAT</p> <input type="checkbox"/> Gagging/Throat Clearing <input type="checkbox"/> Canker Sores |
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How did you hear about us? Check all which apply:

| | |
|----------------------------------------------------------------------------------------------------------------|---------------------|
| Referred by doctor: | Facebook page |
| Referred by therapist: | Insurance Provider: |
| Referred by friend/ family member: | Blog title: |
| Google search: | RBA Website |
| Would you like to receive our monthly newsletter with recipes and nutrition tips to your email? ___ Yes ___ No | |