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 & Employer	
	*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.)
A message: ☐ **can** ☐ **can not be left on my cell phone.** (Please check a box.)

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:		EatRightBucks.com Website
Would you like to receive our monthly newsletter with recipes and nutrition tips to your email? ___Yes ___No			

Office use only

1st Visit Date:	cc/check/cash $	6th Visit Date:	cc/check/cash$_____
2nd Visit Date:	cc/check/cash $_____	7th Visit Date:	cc/check/cash $_____
3rd Visit Date:	cc/check/cash $_____	8th Visit Date:	cc/check/cash $_____
4th Visit Date:	cc/check/cash $_____	9th Visit Date:	cc/check/cash $_____
5th Visit Date:	cc/check/cash $_____	10th Visit Date:	cc/check/cash $_____

PRIVACY CONSENT

Eat Right Bucks County (office of Kristie L. Finnan, RDN, LDN & associates) 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 Eat Right Bucks County may change from time to time. You can get a copy of our revised Notice of Privacy Practices by contacting our office at 215-230-1900 or find it online. 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 Eat Right Bucks County 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 Eat Right Bucks County-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:** _____

RELEASE OF INFORMATION

I give permission for Kristie L. Finnan RDN, LDN and other Registered Dietitians employed at Eat Right Bucks County to:

_____ RECEIVE my medical records from another physician/facility

_____ SEND my medical records to another physician/ facility

Concerning the following named person:

Patient Name: _____

Date of Birth: _____

Street Address:_____

City: _____ State: _____ Zip Code: _____

Authorized records released from: Please fill in the complete name, address and phone number of the physician/ facility in which we are receiving or sending you medical records.

_____

_____

_____

Briefly describe the purpose or need for release: ___*Coordination of Care*_____

_____

This authorization will remain in effect until: _____
This authorization will be effective for medical records generated to the date of signature.
I understand I may revoke this authorization in writing at any time.
Signature of Patient: _____ Date: _____
(If signed by other person other than patient, state relationship to patient)
Legal Authority: _____ Parent: _____ Legal Guardian: _____

POLICIES

Thank you for choosing Eat Right Bucks County (ERBC) for your Nutrition Needs. The following rules will help facilitate a positive working relationship.

1. I hereby authorize ERBC 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 ERBC may bill me for services rendered upon denial of my insurance company-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* if needed prior to your visit and bring it with you. If a referral is faxed, please call to verify that it was received. We are happy to answer any questions you have on how to get your referral. If your insurance requires a referral, a dietitian will not see you unless you self-pay the fee for the entire visit upfront. We will not submit this date of service to insurance; it will simply be an out of pocket expense. We will give you a receipt for the visit. (INITIAL HERE_____).

- Co-pays are due at the beginning of the appointment. *We do not bill insurance for co-pays.* If we are unfamiliar with your insurance policy, we will also collect payment upfront. We will submit to your insurance on your behalf for reimbursement directly to you. (INITIAL HERE_____).

- We require **24 hours notice** to cancel and/or change appointments or a **$50 fee** will be issued. It helps us run our office efficiently and give the best care and service to our clients. Exceptions to 24 hours notice is at the discretion of your Dietitian i.e. illnesses, emergencies, etc. (INITIAL HERE_____).

- 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. We will also take a credit card, but there will be a 5% additional surcharge.**

- If your account is 90 days past due, it will be sent to a collection agency which could A **$25 collections fee** will be issued.

3. We appreciate that all clients will handle any bills in a timely fashion. You will NOT be seen by your Dietitian if you have an outstanding balance.

4. We allow 45-60 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 ERBC 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 can never guarantee coverage. Thank you for your cooperation!

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

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_____ Do you like to cook or want to learn? 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			*Location (kitchen, car, work, bedroom, living room, etc)*
	Time	*Food eaten (Describe)*	
Breakfast			
Lunch			
Dinner			
Snacks			

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(list):
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	Hypothyroidism
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:			
An Exercise Program	Nutrient Testing	Meal Planning	Supplement Recommendations

Any other Questions?

_____

_____

_____

_____