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:			
Referring Physician:	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. 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. 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.
4. Outstanding payments must be made within 90 days of the date of the first statement sent.
5. I acknowledge that 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.
6. I acknowledge if I have a balance on my account and no prior payment arrangement with RBA Billing, my dietitian reserves the right to refuse services until my balance is paid off.

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 90 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.
7. 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.

Late Cancellation Policy

1. I hereby acknowledge that if I fail to cancel my appointment within 48 hours or I miss my appointment I will be billed a $40 late cancellation fee. The fee may be waived on emergency situations.
2. Three (3) missed appointments is considered chronically not showing for appointments, and is subject to the full billed amount for the appointment.

Self-Pay Policies to Know:

1. I understand that a Self-Pay Package must be paid in full at my first appointment and used within one year of the first visit.
2. I understand that a Self-Pay Package offers visits at a discounted rate; therefore, RBA cannot submit these visits to my insurance company.
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 may be used for other services that our office provides (renewing a self-pay package, Spectracell vitamin and mineral blood test, Boston Heart cardiometabolic blood test, resting metabolic testing, etc) or it 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.
6. I understand that failing to provide 48 hours notice of cancellation for scheduled appointments will result in a $40 late cancellation fee.
7. I understand there is no refund for any unused visits on a prepaid package.

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.	
5.	

Please Circle Yes or No to the questions below		
Do you make yourself sick because you feel full?	Yes	No
Do you worry you have lost control over eating?	Yes	No
Have you recently lost more than 14 pounds during the last 3 months?	Yes	No
Do you believe you are fat when others say you are too thin?	Yes	No
Would you say food dominates your life?	Yes	No
Are you satisfied with your eating patterns?	Yes	No
Do you ever eat in secret?	Yes	No

Please list all surgeries		
1.	2.	3.

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

List All Medications You Currently Take Regularly OR As Needed (Prescription & OTC)			
Drug	Dosage	# Times Per Day	Start Date

Height:	Weight:	Do you consider yourself: ___Underweight ___Overweight ___ Just right
List family medical history:		
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:			
Glucose Meter Testing Training	Metabolism Testing	Body Fat Testing	Vitamin and Mineral Deficiency Testing

NUTRITION ASSESSMENT

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

Have you ever worked with a dietitian/nutritionist? Yes _____ No______	If yes, who:
Are you currently engaged in a regular exercise program? If yes, please describe and how often:	
Do you cook? Yes ______ No_____	
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: ________

Please record what you ate and drank yesterday			Location (kitchen, car, work, bedroom, living
	Time	Food eaten	
Break fast			
Lunch			
Dinner			
Snacks			

Symptom Survey

CONSTITUTIONAL	WEIGHT MANAGEMENT	DIGESTIVE	EMOTIONAL/MENTAL
○ Fatigue (sluggish, tired) ○ Sleepiness During Day ○ Insomnia at Night ○ Malaise (Feeling Lousy) ○ Seizures HEAD/ EARS ○ Headache (any kind) ○ Earache ○ Ear Infection ○ Ringing in ears ○ Itchy Ears ○ Sensitivity to Sound MUSCULOSKELETAL ○ Joint Pain/Aching ○ Muscle Aches ○ Stiff Muscles ○ Ticks (facial or otherwise) ○ Muscle Spasms ○ Muscle Cramps	○ Fluctuating Weight ○ Food Cravings ○ Water Retention ○ Binge Eating ○ Binge Drinking ○ Purging (all methods) NASAL/ SINUS ○ Post Nasal Drip ○ Sinus Pain ○ Runny Nose ○ Stuffy Nose ○ Sneezing LUNGS ○ Wheezing ○ Chest Congestion ○ Dry Cough ○ Wet Cough ○ Shortness of Breathe	○ Heartburn/Reflux ○ Stomach Pains/Cramps ○ Constipation ○ Diarrhea ○ Bloating Sensation ○ Gas (of Any Kind) ○ Nausea, Vomiting ○ Painful Elimination MOUTH/ THROAT ○ Sore Throat ○ Swollen Throat ○ Swelling/burning lips/ tongue ○ Gagging/ Throat Clearing ○ Canker Sores ○ Difficulty Swallowing GENITOURINARY ○ Increase urinary frequency ○ Painful urination ○ Bladder pain ○ Bedwetting	○ Depression ○ Anxiety ○ Mood Swings ○ Irritability ○ Lack of concentration/focus CARDIOVASCULAR ○ Irregular Heartbeat ○ High Blood Pressure SKIN ○ Blemishes, acne ○ Rashes or hives ○ Eczema or psoriasis ○ "Rosy" cheeks ○ Flushing ○ Itchy Skin EYES ○ Red or Swollen Eyes ○ Watery Eyes ○ Itchy Eyes ○ Dark Circles or "Bags" ○ Sensitivity to Light ○ Aura

How did you hear about us? Check all which apply:			
	Refered 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______