REBECCA BITZER & ASSOCIATES
A Dietitian for Every Condition

Patient Name: First	Middle	Last		Home Phone Number:	
Home Address: Apt. No.	City:			State	Zip Code:
Occupation:	Relationship Status:	Date of Birth:		Age:	Gender:
E-mail address:	Cell Phone:				
Employer:	Address:	Work Phone Number:			
Partner (or parent) name:					
Partner (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 & Associates (RBA). Medical Nutrition Therapy (MNT) is covered by many insurance plans. By signing below, you agree to these terms. We will use your insurance benefits when possible. MNT is defined as face-to-face medically necessary nutrition counseling. We will also provide additional non-covered services when necessary to help you meet your nutrition goals. Here are our billing terms:

1. If using health insurance benefits:
    a. 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. I authorize RBA to share information about me and my treatments for payment processing and as otherwise provided in our Privacy Notice.
    b. If required by my insurance, it is my responsibility to bring a proper referral (and/or obtain any required pre-authorization) and copay to my appointment.
    c. I understand that RBA will verify my benefits prior to my appointment, however, that is not a guarantee of coverage. I understand that if my insurance company does not cover MNT for any reason (including a lack of any needed referral or pre-authorization), I will be responsible for all non-covered services rendered. If we are uncertain of coverage, we will keep a deposit or credit card on file until we are compensated by the insurance company.
2. All fees are due at the time of service or when invoiced. Clients must have a zero balance in order to be seen. Additional fees include:
    a. Fee for returned check ($25)
    b. Fee for missed or cancelled appointments (for cancellations within 48 hours of appointment time) ($40)
    c. There will be a 15% fee added to bills that are 30 days overdue, 30% added to bills that are 60 days past due and 45% to bills that are 90 days past due. After 90 days balances will be sent to collections.
3. Self-Pay Services:

    We have discounted, prompt pay fees available. These services are available to you if your insurance does not cover your nutrition counseling or if your Registered Dietitian Nutritionist advises non-covered services.

    a. Nutrition Counseling either in person or via telehealth
        i. Basic Self-Pay Packages (SPP)
            1. Get to know you $75 initial session (30 minutes)
            2. Three visit SPP $360 (45 minutes) or six mini visits
            3. Couples Three visit SPP $531
        ii. Specialized Self-Pay Fees
            1. Eating Disorder Session $175/session
            2. Daily Remote Monitoring $250/month
            3. Digestive Session (no testing) $175/session
            4. Sports Nutrition (3 visit, RMR, BF analysis, meal plan) $495
        iii. Other
            1. Customized Meal Plans $250
            2. Workbook $25
    b. Testing
        i. RMR Metabolism Testing $50 (for RBA clients that obtain other RBA nutrition counseling services) $100 for non-nutrition counseling clients
        ii. Body Fat Analysis $50 (for RBA clients that obtain other RBA nutrition counseling services) $100 for non-nutrition counseling clients
        iii. RMR metabolism Testing and the Body Fat Analysis package $75 for RBA Clients
        iv. MRT/LEAP food sensitivity testing $435 + $25 for blood sample collection. Itemized receipts will not be available upon request, therefore FSA and HSA cards are not permitted to be used for this test.
        v. SpectraCell $275- $475 (estimated patient co-pay portion, assuming balance paid through patient insurance, full test charge: $_____ – please note: we do <u>not</u> accept Medicaid). Itemized receipts will not be available upon request, therefore FSA and HSA cards are not permitted to be used for this test.
        vi. Nutrigenomix Saliva Test $395
        vii. Genova Stool Testing if BCBS, Cigna or UHC $171.
    c. Other services

        _____
        _____
        _____

4. RBA may change these terms by providing notice to me by email or by regular mail sent to any email address or postal address on file with RBA. Updated terms will apply as of the effective date specified in any notice of change in terms.

5. How We Will Communicate With You:

Use of Telephone:

If you provide us with a telephone number, we may contact you using that telephone number to discuss your services, appointments, records, and purchases.

Use of Electronic Communication Methods:

Electronic communications include email messages, internet communication services (such as Skype™), or other electronic methods. You agree that electronic communications are not secure and that there is the possibility that they may be accessed by other persons. You also agree that your employer may review any electronic communications transmitted through your employer's computer system. We may use email or other electronic communications to transmit routine information to you (such as appointment dates, newsletters, etc.). We may also use email or other electronic communications to transmit information concerning your services and products, unless you tell us otherwise (as described below). If you give us an email address or communicate with us using other electronic communications, you agree that: (a) electronic communications should not be used for emergency or other time-sensitive situations or where sensitive information will be transmitted (please contact us by telephone or visit our location); (b) we will use reasonable efforts to respond to electronic communications that you send (if

you do not hear from us within 2 business days, please contact us by telephone or visit our location) and we will not be liable for any failure to respond or any intercepted electronic communications; (c) one or more of our staff members may need to access your electronic communications in order to help us respond; and (d) we may keep copies of electronic communications that you send in your client records.

If you do not wish us to use electronic communications to transmit information concerning your services/products, you can provide written notice to us at admin@rbitzer.com or at 301-474-2499.

I agree to the above terms.

Signature _____

Date_____

REBECCA BITZER & ASSOCIATES
A Dietitian for Every Condition

Credit Card Payment Authorization:

Please sign below to authorize RBA to use this credit card for fees and charges related to your RBA services/products. Your authorization will remain in effect until you cancel it by calling us at 301-474-2499 or emailing us at admin@rbitzer.com .

Account Type: ☐Visa ☐MasterCard ☐American Express ☐Discover

Cardholder Name: _____

Credit Card Number: _____

Expiration Date: _____

CSV Code:_____

☐I authorize you to use the above credit card to pay for services that I request from time to time.

_____ _____

Client 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
Regular bowel movements	Yes	No

Pleaselist all surgeries		
1.	2.	3.

Circle (Or Write In) All Medical Conditions Previously Diagnosed and/or Symptoms				
Diabetes	Anorexia	Inflammatory Bowel Disease	CKD (Chronic Kidney Disease)	Migraine/ headaches
High Cholesterol	Bulimia	Irritable Bowel Syndrome	Cancer	Arthritis
Hypertension	Binge Eating	Celiac Disease	Bloating/Distention	Eczema/skin diagnosis
PCOS	Food Cravings	Lactose Intolerance	Joint Pain	Fatigue
Sleep apnea	Depression	Diarrhea	Other:	Insomnia
Infertility	Anxiety	Constipation	Other:	Other:
Food Allergies	Emotional Eating	Gas/Belching	Other:	Other:
Gastroesophageal Reflux	Attention Deficit Disorder	Nausea/vomiting	Other:	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:		
List any Allergies- Food and Environment		

Are you interested in any of the following? Please circle:			
Glucose Meter Testing Training	Metabolism Testing	Body Fat Testing	Vitamin and Mineral Deficiency Testing
Food Sensitivities testing	Stool testing	Genetic Testing	Cardiometabolic 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:	
How many hours of sleep do you get? Any issues falling asleep?	
Stress Level: 1-10 (10 being the highest) :	
Do you cook? Yes _____ No_____	
Please add any other comments that you would like us to know:	

REBECCA BITZER & ASSOCIATES
A Dietitian for Every Condition

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: _____
Do you avoid any foods? Why?
Alcohol/drug consumptions?

Please record what you ate and drank yesterday			Location (Kitchen, car, work, living room, ect.)
	Time	Food eaten (Describe)	
Breakfast			
Lunch			
Dinner			
Snacks			

REBECCA BITZER & ASSOCIATES
A Dietitian for Every Condition

AUTHORIZATION TO OBTAIN/ RELEASE CONFIDENTIAL INFORMATION

I Authorize Rebecca Bitzer and Associates to

- Discuss my treatment progress
- To obtain medical records and/or progress notes
- To release medical records and/or progress notes

With/To/From the following individuals:

Primary Doctor:

Name: _____ Address: _____

Phone: _____ Email:_____

Therapist:

Name:_____ Address:_____

Phone: _____ Email:_____

Treatment Center:

Name:_____ Address:_____

Phone:_____ Email:_____

Other:

Name:_____ Address:_____

Phone:_____ Email:_____

I understand that my records and treatment are confidential and will not be disclosed without my written consent unless under legal compulsion. I also understand that I may revoke this consent at any time, except to the extent that action has been taken in reliance therein.

Date :_____ Client Signature:_____

Address:_____

Parent/Guardian Signature:_____

Therapist/Dietitian Signature:_____