BANISTER
NUTRITION LLC
CHANGING HABITS
CHANGING HEALTH
CHANGING LIVES

Mercy Tower, Suite 508
4200 W. Memorial Road
Oklahoma City, OK 73120
405.755.7561

Medical/Nutrition History

Referred by _____ Date _____

To be filled out by the Client

Client's Name _____ Parent's Name (if client is a minor) _____

Date of birth _____ Sex _____ Age _____ SSN _____

Address _____

City _____ State _____ Zip _____

Home Phone ( ) _____ Work Phone ( ) _____ Cell Phone ( ) _____

Email Address _____

Occupation/Employer _____ Work Hours _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed

Number of persons in household: Adults _____ Children _____

PLEASE FILL OUT INSURANCE INFORMATION COMPLETELY! Thank you!

Insurance Company _____ Policy # _____

Secondary Insurance _____ Policy # _____

Subscriber's Name _____

Subscriber's SSN _____ Subscriber's DOB _____

Employer of Subscriber _____

Relationship to Subscriber _____

Primary Physician _____ Date of last checkup _____

Reason for referral to this office? _____

How long have you had this condition/disease? _____

Under other physician's care? ☐ Yes ☐ No If so, who and for what? _____

To be filled out by the Client | For dietitian use only

Personal Medical History. Check all conditions that apply.

☐ Heart disease or stroke	☐ Food allergies	☐ Anemia
☐ High blood pressure	☐ Diabetes	☐ Depression
☐ Hyperlipidemia	☐ Obesity	☐ Major surgery
☐ Thyroid/other	☐ Arthritis	☐ Hypoglycemia
☐ Hormone conditions	☐ Dentures	☐ Indigestion
☐ Cancer	☐ Chewing problems	☐ Physical handicaps
☐ Lung problems	☐ Constipation	☐ Surgeries
☐ Food sensitivities	☐ Diarrhea	☐ Other
☐ Ulcers	☐ Gastrointestinal disorders	

Family Medical History: Check conditions that apply

☐ Heart disease or stroke	☐ Food allergies
☐ High blood pressure	☐ Diabetes
☐ Hyperlipidemia	☐ Obesity
☐ Thyroid/other Hormone conditions	☐ Arthritis
☐ Cancer	☐ Gallbladder disorder
☐ Lung problems	☐ Gastrointestinal disorders
☐ Food sensitivities	☐ Other allergies
☐ Other	

List all medications you are taking	Time of Day	Amount	Purpose

Reactions to any medications_____

Alcohol intake: # drinks per day_____ per week_____

Type of alcohol_____

Tobacco usage: ☐smoker ☐non smoker quit smoking _____years ago

Chewing tobacco: ☐Yes ☐No

Height _____ Current Weight_____ Usual Weight_____ Highest Weight_____

Goal Weight_____ Pounds gained this year_____ Pounds lost this year_____

Is anyone in your family overweight? ☐Yes ☐No If so, who?_____

To be filled out by the Client	For dietitian use only
Have you ever taken diet pills? ☐Y ☐N Have you ever been on a special diet before? ☐Y ☐N If yes, what type and when?_____ _____ _____ Did you stay on the diet? ☐Y ☐N List any problems you had with the diet:_____ _____ Have you ever seen a registered dietitian before? ☐Y ☐N If so, where?_____ _____ List any vitamins/minerals or any other kinds of supplements you are taking:_____ _____ _____	Diet History: Supplements:
Anyone else in the household on special foods/diets? ☐Y ☐N If so, what type of foods/diets:_____ Who cooks meals?_____ Who does the grocery shopping?_____ Out of 21 meals/week, what % are prepared at home?_____ How are most foods prepared at home? Baked Boiled Fried Other How often do you dine out a week, including carryout or deliver?_____ _____ What restaurants do you frequent?_____ _____ _____	
Do you exercise regularly? ☐Y ☐N If so, what type?_____ _____ Times per week_____ Total number of hours per week_____ Where do you exercise?_____ _____	
Identify your stress level ☐High ☐Moderate ☐Low On an average, how many hours of sleep do you get a night?_____ Any personal problems in the last 12 months? (family problems, death of family members, marital problems, divorce, job change, accidents, illness)_____ _____ _____	

To be filled out by the Client		For dietitian use only
How would you generally describe your eating habits? ☐Good ☐Fair ☐Poor		
Has your appetite changed recently?	☐Y ☐N	
How long does it take to complete a meal? _____ hours _____ mins		
Do you have trouble eating, chewing or swallowing?	☐Y ☐N	
Have you ever gone on an eating binge?	☐Y ☐N	
Does this still occur?	☐Y ☐N	
Have you ever induced vomitting after you eat?	☐Y ☐N	
Do you ever feel extremely guilty after eating?	☐Y ☐N	
Do you ever find yourself preoccupied with food?	☐Y ☐N	
Do you avoid foods that contain sugar or fat?	☐Y ☐N	
Have you ever taken laxatives or diuretics to lose weight?	☐Y ☐N	
Do you skip meals?	☐Y ☐N	
If so, which meal or meals?_____		
_____		
Where do you eat most of your meals at home?_____		
Do you watch TV when you eat?	☐Y ☐N	
Do you clean your plate even when full?	☐Y ☐N	
Do you eat standing up?	☐Y ☐N	
Do you eat when preparing food or storing leftovers?	☐Y ☐N	
Do you salt food at the table regularly?	☐Y ☐N	
Do your emotions/feelings affect your food choices?	☐Y ☐N	
During the past month have you often been bothered by:		
1) little interest or pleasure in doing things you once enjoyed	☐Y ☐N	
2) feeling down, depressed or hopeless	☐Y ☐N	
		Goals:
Do you feel that you will be able to follow a nutrition program?	☐Y ☐N	
Explain:_____		
_____		
_____		
What are your nutrition related goals?_____		
_____		
_____		
_____		
_____		
_____		
_____		

To be filled out by the Client

What expectations do you have working with a registered dietitian?_____

_____

_____

_____

_____

_____

_____

For dietitian use only

Expectations:

For patients with Diabetes:

Are you monitoring your blood glucose? ☐Y ☐N

If yes, how many times per week:_____

Please indicate your blood sugar readings:

Time of Day	Blood Glucose Reading

Are you experiencing any problems with your diabetes management? If so, Please explain:

_____

_____

_____

_____

_____

_____

_____

Diabetic Management:

Please continue to the next page for food diary information.

Food Diary:

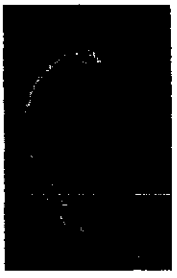
Please include records of intake for one week-day and one weekend day. Include all meals, snacks and drinks.

Day 1

Date	Time	Food or Beverage	Amount/Portion Size

Day 2

Date	Time	Food or Beverage	Amount/Portion Size



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GUARANANTEE AND CANCELATION POLICY

- All appointments are guaranteed specifically for you by a credit card number provided to us.

- You may ***cancel*** or ***change*** your appointment anytime provided it is 24 hours or more prior to your scheduled appointment. If you do not cancel or change your appointment 24 hours in advance you will be subject to a charge for the block of time we reserved for you. This charge will be placed on your credit card.

- Please understand less than 24 hours notice of cancellation or desire to change your appointment time does not allow us enough time to fill your reserved time slot with someone else.

- Cancellations or appointment change requests must be made by calling our office because e-mails are not checked regularly.

- We will ask for a copy of your credit card at the time of your appointment.

I have read and accept the 'Guarantee and Cancellation' policy of ***Banister Nutrition.***

Signature **Date**

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RECORDS RELEASE

Please list names of any physicians and/or counselors who are currently providing you with medical care. It may be necessary for our registered dietitians todiscuss your medical needs/care, obatin lab work, or provide written reports concerning your medical care with the health care provider. Please indicate 'yes' if you agree that we may contact these providers.

Health Care Provider	Phone	Address	Yes	No
			☐	☐
			☐	☐
			☐	☐
			☐	☐

Patient or Guardian Signature_____ Date_____

RECEIPT OF PRIVACY POLICY:

I acknowledge receiving a copy Banister Nutrition Consulting "Notice of Private Practice"

Patient or Guardian Signature_____ Date_____

CONTACT PHONE NUMBERS:

Please provide at least two phone numbers that we may use to contact you for appointment confirmations, or in the event of an emergency.

Home #_____ Work #_____ Cell #_____
For text reminders

I approve Banister Nutrition to contact me at any of the numbers listed above. Please list any privacy guidelines you would like us to specifically respect.

_____

_____

_____

Patient or Guardian Signature_____ Date_____

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ASSIGNMENT OF BENEFITS

(Please disregard this page if you are not using insurance coverage.)

I acknowledge receipt of medical services and authorize the release of any medical information necessary to process this claim for health care payment only.

I hereby instruct and direct the *insurance company designated below to issue direct payment to Banister Nutrition for the medical expenses allowed under my current insurance policy. Such payment shall be applied towards the total charges for the services rendered on my behalf by Banister Nutrition and that are invoiced to my insurance company. This assignment is a direct assignment of my rights and benefits under my insurance policy. I agree to pay to Banister Nutrition, in a current and timely manner, any balance of medical charges and expenses over and above the amount of the allowed insurance payment, including charges for any services not covered by insurance, co-pays, expenses and any deductibles that are required pursuant to the above mentioned insurance policy.

*Please remember it is your responsibility to determine if your insurance policy will cover the services of a registered dietitian to provide medical nutrition therapy to you.

_____ _____
Patient's Signature Date

_____ _____
Patient's Name Printed Social Security No.

_____ _____
Patient's Agent or Guarantor Relationship

_____
Reason for Other Patient's Signature

Name of **Primary** Insurance Co:_____

Group Number/Policy Number:_____

Name of **Secondary** Insurance Co:_____

Group Number/Policy Number:_____

Medicare -- Claim Number:_____

Effective Date (Part A)_____ Effective Date (Part B)_____

[redacted]

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OFFICE PROCEDURES

CONSULTATION FEES: Banister Nutrition Therapy fees will be billed according to the Insurance payment schedule, but will never exceed more than the discounted prices in the event Insurance makes the service self-pay. Those prices range from $100 for a 30 minute session to $250 for an hour and a half.

INSURANCE: Banister & Associates are participating providers for the following: Aetna US Healthcare, Blue Cross/Blue Shield of Oklahoma, PPO Oklahoma First Health, Community Care HMO, Preferred Community Choice, Health Choice, Pacific Care PPO, Conventry Health Care, United Health Care, and Medicare.

With appropriate authorization/referral from your primary care physician, insurance will be filed on your behalf. All co-pays are due at the time of service. Remember your insurance benefits are a contractual agreement between you and your insurance company. Banister and Associates can never guarantee what you and your insurance company have contracted as your covered benefits.

Any insurance company not listed above **may** cover medical nutrition therapy, but it is **your** responsibility to contact **your** insurance company to determine your benefits. We request that you pay for services at the time they are provided. We will file for your insurance coverage for you. If we receive payment, we will then reimburse you.

YOU, THE PATIENT, ARE RESPONSIBLE FOR FEES INCURRED SHOULD YOUR INSURANCE DENY PAYMENT.

We accept cash, checks, Visa and Master Card.

I have read, understand and accept my responsibility regarding my insurance and payment for professional services provided to me.

Signature and Date

Thank You.

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2019 PAYMENT POLICY

- ***YOU*** are responsible for all payment of services received from January 1st thru December 31st, 2019.
- Banister Nutrition is a contracted provider with: Aetna; Blue Cross/Blue Shield; Cigna; Community Care; Health Choice; Coventry Health Care; United Health Care; Medicare; Medicaid/Sooner Care.
- Your insurance company chooses to not guarantee payment of most medical services.
- ***A physician referral and diagnosis code must be received from your referring physician*** in order for us to file insurance benefits on your behalf.
- For Medicare coverage, your referring physician must be a Medicare provider.
- All co-pays are due at the time services are rendered.
- Payment in full is required at the time of service if we are not contracted with your insurance company. As a courtesy, upon request, we will file for "out of network" benefits for you.
- All balances remaining after your insurance has been processed and any missed appointment charges will be considered **balances due from patient. Balances due from patient will be applied to your credit card on file if not paid upon billing.** If you prefer we not use your credit card on file, you may pay in full at the time of your appointment.
- Fees for missed appointments: 1 hr- $150; 45 mins- $120; 30 mins- $100
- We accept cash, check, Visa, Mastercard, Discover and money orders.
- I understand that insurance might deny if the diagnosis is not covered by my policy or the number of visits have been exceeded. I agree to be fully responsible for any balances. Overpayments will be refunded to me.

I understand and accept my responsibility for the "Payment Policy" as described above.

Signature Date