

Referral Source (Please Check One):  Physician  Self  Other Date: \_\_\_\_\_

## Contact Information

Patient's Name: \_\_\_\_\_  
Parent's Name (if Client is a Minor): \_\_\_\_\_  
Race/Ethnicity: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Gender: \_\_\_\_\_ Age: \_\_\_\_\_  
Street Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
E-mail Address: \_\_\_\_\_  
How Did You Find Us? \_\_\_\_\_

## Insurance Information

Insurance Company: \_\_\_\_\_ Policy #: \_\_\_\_\_  
Secondary Insurance: \_\_\_\_\_ Policy #: \_\_\_\_\_  
Subscriber's Name: \_\_\_\_\_  
Subscriber's SSN: \_\_\_\_\_ Subscriber's DOB: \_\_\_\_\_  
Employer of Subscriber: \_\_\_\_\_  
Relationship to Subscriber: \_\_\_\_\_

## Healthcare Information

Please list the names of any physicians, counselors, or other healthcare professionals who are currently providing you with care related to the reasons for your visit. It may be necessary for our registered dietitians to discuss your medical needs/care, obtain lab work, or provide written reports concerning your medical care with these health care providers.

Primary Physician: \_\_\_\_\_ Date of Last Visit: \_\_\_\_\_  
Referring Physician: \_\_\_\_\_ Reason for Referral: \_\_\_\_\_  
Other Physician: \_\_\_\_\_ Specialty: \_\_\_\_\_  
Other Provider: \_\_\_\_\_ Provider Type: \_\_\_\_\_  
Other Provider: \_\_\_\_\_ Provider Type: \_\_\_\_\_

**\*\*Please Indicate Yes or No to the Following Statement:**

*I agree that Banister Nutrition may contact and be contacted by the above listed providers to exchange information regarding my medical and nutritional care.*

- Yes  
 No

Initials: \_\_\_\_\_

## Medical History

Please carefully review the list below and select all conditions or symptoms that apply.

<input type="checkbox"/> Abdominal Surgery <input type="checkbox"/> Anemia <input type="checkbox"/> Anxiety <input type="checkbox"/> Autoimmune Disease <input type="checkbox"/> Asthma <input type="checkbox"/> Arthritis <input type="checkbox"/> Cancer (specify): _____ <input type="checkbox"/> Celiac Disease <input type="checkbox"/> Chronic Back Pain <input type="checkbox"/> Congestive Heart Failure <input type="checkbox"/> Constipation <input type="checkbox"/> Crohn's Disease <input type="checkbox"/> Chewing Difficulties <input type="checkbox"/> Dentures <input type="checkbox"/> Depression <input type="checkbox"/> Diabetes <input type="checkbox"/> Dialysis <input type="checkbox"/> Diarrhea <input type="checkbox"/> Disordered Eating <input type="checkbox"/> Food Allergies <input type="checkbox"/> Food Sensitivities <input type="checkbox"/> Gallbladder Disease <input type="checkbox"/> Gastric Bypass <input type="checkbox"/> Gout	<input type="checkbox"/> Headaches / Migraines <input type="checkbox"/> Heart Disease / Heart Attack <input type="checkbox"/> High Blood Pressure / HTN <input type="checkbox"/> High Cholesterol <input type="checkbox"/> High Triglycerides <input type="checkbox"/> History of Trauma / Abuse <input type="checkbox"/> Hormone Imbalances <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Heartburn/GERD <input type="checkbox"/> Immunosuppression <input type="checkbox"/> Infertility <input type="checkbox"/> Irritable Bowel Syndrome (IBS) <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Kidney Stones <input type="checkbox"/> Liver Disease <input type="checkbox"/> Low Energy Level <input type="checkbox"/> Lung Disease <input type="checkbox"/> Menstrual Irregularity <input type="checkbox"/> Nausea/Vomiting <input type="checkbox"/> Neurological Disease <input type="checkbox"/> Obesity <input type="checkbox"/> Osteoporosis / Osteopenia <input type="checkbox"/> Pancreatitis <input type="checkbox"/> Psychological Condition	<input type="checkbox"/> Rashes / Skin Problems <input type="checkbox"/> Recent Hospitalization <input type="checkbox"/> Recent Infection <input type="checkbox"/> Sickle Cell Disease <input type="checkbox"/> Sleep Apnea / Sleep Disorder <input type="checkbox"/> Stomach Ulcers <input type="checkbox"/> Swallowing Difficulties <input type="checkbox"/> Thyroid Disease <input type="checkbox"/> Urinary Difficulties <input type="checkbox"/> Other: _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____  <b>Do you have a family history of the following?</b> <input type="checkbox"/> Cancer <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Disease <input type="checkbox"/> Gastrointestinal Disorders <input type="checkbox"/> Obesity <input type="checkbox"/> Other: _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____ <input type="checkbox"/> _____
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**Prior Surgeries:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Current Medications, Vitamins, and Dietary/Herbal Supplements (Attach a Separate List if Needed):**

Name	Dose / Amount	Time	Purpose

## Nutrition Questionnaire

Height: \_\_\_\_\_

Current Weight (Optional): \_\_\_\_\_

How Do You Currently Rate Your Health? (Check One)       Excellent    Good    Fair    Poor

Have You Met with a Dietitian or Followed a Nutrition Program Before?       Yes    No

If yes, please describe: \_\_\_\_\_

Do You Currently Follow a Special Diet?       Yes    No

If yes, please describe: \_\_\_\_\_

Do Any Religious Practices or Food Philosophies Affect Your Food Choices?       Yes    No

If yes, please describe: \_\_\_\_\_

Has Your Weight Changed Significantly Recently? (Gain / Loss of 10+ lbs within 3 months)       Yes    No

If yes, please describe: \_\_\_\_\_

Has Your Appetite Changed Significantly Recently?       Yes    No

If yes, please describe: \_\_\_\_\_

### Please List Current Food Allergies or Sensitivities

Food Item / Ingredient	Reaction

### What Are Your Top Nutrition / Health-Related Goals?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

### What Kind of Support From a Dietitian are You Looking For (E.g. Specific Information, etc.)?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



## Payment Policy

**\*Please note that you are responsible for all payment of services received from January 1st to December 31st, \_\_\_\_\_.**

Banister Nutrition is a contracted provider with: Aetna, Blue Cross/Blue Shield, Cigna, Community Care, HealthChoice, Coventry Health Care, United Health Care, Medicare, and Medicaid/Soonercare. **Banister Nutrition does not participate in any HMO insurance plans. We will not bill any HMO insurance plan. If you carry an HMO plan, you will be required to pay as a self-pay patient at the time of service.**

**A physician referral and diagnosis code (ICD-10) must be received** in order for us to bill our services through your insurance plan. This, however, is not the same as an authorization or guarantee of coverage from your insurance company.

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 due at the time of service if we are not contracted with your insurance company. As a courtesy, we will file for “out of network” benefits for you.

Banister Nutrition can never guarantee what you and your insurance company have contracted as your benefits. Therefore, we do not guarantee coverage of any services provided by our dietitians. **Some insurance policies do not cover nutritional services. We can provide you with your billing codes and diagnoses so that you can call your insurance company to verify.**

**All balances remaining after your insurance has been processed and any missed appointment charges will be considered balances due from the patient (or guardian).**

**Balances due will be applied to your credit card on file if not paid upon billing.** If you prefer we not use your credit card, you may pay in full by another method at the time of your appointment. Any overpayments made will be refunded to the patient (or guardian).

**\*Please acknowledge, by signing below, that you understand and accept responsibility for the Payment Policy as described above. Thank You.**

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Signature

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Date

## 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 toward the total charges for services rendered on my behalf at Banister Nutrition 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 Banister Nutrition, in a 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 note that 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.**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name of Patient

\_\_\_\_\_  
Patient's Agent or Guarantor

\_\_\_\_\_  
Relationship

\_\_\_\_\_  
Reason for Other Patient's Signature



## Guarantee and Cancellation Policy

**\*Please note that all appointments are guaranteed specifically for you by a credit card number provided to us. We will ask for a copy of your credit card at the time of your appointment to keep on file for this purpose.**

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 at least 24 hours in advance, you will be subject to a charge with the credit card on file for the time we reserved for you.**

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

Cancellations or change requests must be made by calling our office, as e-mail is not checked regularly.

**\*Please acknowledge, by signing below, that you understand and accept responsibility for the Guarantee and Cancellation Policy as described above. Thank You.**

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Signature

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Date