



1104 Village Oaks Drive
 Mount Airy, MD 21771
 Office: (301) 502-7823
 Fax: (301) 829-8380

PATIENT REGISTRATION

(Please print clearly)

Name: First	Middle	Last	Date of Birth:
Address: Street	City	State	Zip Code
What phone can a message be left on?		E-Mail Address	
Home Phone:	Cell Phone:		
Age:	Sex:	Marital Status:	
Work Phone:	Actual Weight:		
Height:	Highest Adult Weight:	Lowest Adult Weight:	
Spouse (or Parent) Name:		Spouse/Parent Employer:	
Spouse/Parent Work Phone Number:			
Family Physician:	Address:	Phone Number:	
Referred By:	Address:	Phone Number:	

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:

Do you have any other Insurance? Yes No (If yes, please specify)

CONSENT FOR TREATMENT

- I understand the results are not guaranteed.
- I give Four County Nutrition permission to send a summary note to my physician or referring doctor of my consultation here.
- I acknowledge that I have the right to have a copy of these policies.

Patient's Signature: _____ **Date:** _____

Staff Signature: _____ **Date:** _____

POLICY CONCERNING PAYMENT OF MEDICAL BILLS & OFFICE BILLING

I, _____, hereby authorize Four County Nutrition to apply for benefits on my behalf for covered services rendered by Four County Nutrition, and request that payments be made directly to Four County Nutrition. I certify that the information I have reported with regard to my insurance coverage is correct and further authorize the release of any necessary information, including medical information for this or any related claims.

I understand that Four County Nutrition may bill me for services rendered, if my insurance company or Medicare fails to assign payment to Four County Nutrition despite prior approval of services. I agree to be fully and personally responsible for payment. Four County Nutrition agrees to refund me any duplicate payments.

I understand co-pays are due at the time of the appt. A \$15 late fee will be charged on co-payments not paid at the time of service.

I understand that if you have pre-paid fees packages or follow-up appointments, these fees will not be refunded or exchanged and your appointment will be forfeited if you do not show or if you cancel your appointment with less than 24 hours.

I understand the **Cancellation Policy**: We have a fixed and moderate patient load so that we can provide the best quality of care for you. **We strive to see you on time because we value your time as well as ours.** When you have a scheduled appointment, that time is reserved solely for you. If you cancel an appointment, you must do so at least 24 hours in advance. If you cancel less than 24 hours in advance you will be charged for your missed appointment unless it is made up during the following 7 days. Make-ups may be available during the week of the appointment if space exists.

Charge for first missed appointment - \$50.00

Charge for second and all subsequent missed appointments - \$100.00

These cancellation charges are **not** reimbursable by your insurance company.

I understand 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 only.** I understand there is a **\$25 fee for any account sent to collections.**

I have read, understand, understand that a copy is available upon request of these policies.

Signature: _____ Date: _____

PRIVACY CONSENT

Four County Nutrition 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 Four County Nutrition may change from time to time. You can get a copy of our revised Notice of Privacy Practices by contacting our office at 240-215-5084. We will also post a copy of our current Notice of Privacy Practices in our office.

You have the right to request that Four County Nutrition restrict how it uses or discloses protected health information to carry out treatment, payment or health care operations. Four County Nutrition does not have to agree to such requests, but must honor the requests to which it agrees.

You have the right to revoke this consent in writing and the revocation will be effective except to the extent Four County Nutrition has acted in reliance on your consent.

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: _____

NUTRITION ASSESSMENT

Reason for today's visit: _____

1. Have you ever worked with a dietitian/nutritionist? Yes ____ No ____

If yes, Who: _____

2. List any medications that you are currently taking and their uses:

-
-
-
-

3. List any herbal and/or vitamin/mineral supplements you are taking:

4. Are you currently engaged in a regular exercise program? Yes ____ No ____ Please describe:

Current:

Type:

Intensity:

Length of time:

Days/week:

Past: _____

5. Any symptoms of nausea vomiting diarrhea constipation (circle all that apply)

6. Is there any family medical history that we should be aware of (please circle):

Diabetes- Type I / Type II

High Blood Pressure

Heart Attack or Stroke before age 50

Other: _____

7. Do you smoke cigarettes? _____

8. Do you experience mood swings, nervousness, or mental tension (please circle)?

9. Is there any other medical information concerning you that we should be aware of:

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

11. List your hobbies, television habits, and reading habits _____

12. Please add any other comments that you would like us to know:

FOOD QUESTIONNAIRE

Food Likes: _____

Food Dislikes: _____

Eating Out: How many times per week to eat the following meals out:

Breakfast: _____ Lunch: _____ Dinner: _____

Restaurants: _____

How many times a day do you eat foods in the following categories?

Foods

1. Fruits: _____
2. Vegetables: _____
3. Bread, Pasta, Rice: _____
4. Beans: _____
5. Nuts: _____
6. Red Meat: _____
7. Chicken: _____
8. Fish: _____
9. Tofu/Soy: _____
10. Dairy Foods (Yogurt, Cheese): _____
11. Chips, Crackers, Pretzels, Snacks: _____
12. Sweets: _____

Beverages

1. Water: _____
2. Juice: _____
3. Milk: _____
4. Sodas: _____
5. Beer, Wine, Mixed Drinks: _____

Please record what you eat and drink on a "typical day"

Meal	Time	Food Eaten	Location of Meal
Breakfast			
Lunch			
Dinner			
Snacks			

(For Office Use Only)

Patient Summary:

Patient reported to our office with a diagnosis of:

Type I DM 250.01	Hyperlipidemia 272.4	
Type II DM 250.0	Bulimia Nervosa 307.51	Obesity 278.00
Gestational Diabetes 648.80	Anorexia Nervosa 307.1	GERD 530.81
Hypertension 401.9	Hypoglycemia 251.2	Food Allergy 693.1
Other:		

Diet History Reveals:

Currently the patient exercises:

Medical Nutrition Therapy Provided On:

Heart Healthy Eating	Blood Glucose Monitoring
Eating Out Guidelines	Signs/Symptoms of Low/High Blood Sugar
Portion Control	Short/Long Term Complications of DM
Appropriate Snacking	Basic Diabetes Meal Guidelines
Benefits of Exercise	Carbohydrate Counting
Food Allergy (specify)	Meal Plan Guidelines
_____	Importance of Medication Compliance

Other:

Comments:

Comprehension was:	GOOD	FAIR	POOR
Expected Compliance is:	GOOD	FAIR	POOR

Goals:

1.

2.

3.

Follow-up will occur in _____ week(s).

RD Signature: _____ Date: _____