

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"/> _____ Do you have a family history of the following? <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.**

Banister Nutrition is a contracted provider with: Aetna, BlueCross BlueShield, Cigna, Community Care, Coventry Health Care HealthChoice, Humana, Medicare, Medicaid/Soonercare, Tricare Standard, and United Healthcare. **Being a contracted provider does not guarantee coverage within your personal policy. Banister Nutrition has limited participation in HMO insurance plans. If Banister Nutrition does not participate in your HMO insurance 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 diagnosis-specific 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**. Medicare covers only **Renal diseases, Type 1 and 2 Diabetes**.

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. **We can provide you with your billing codes and diagnoses so that you can call your insurance company to verify if you would like.**

Nutrition therapy fees are \$100 for a 30 minute session to \$250 for a 90 minute session. If your insurance denies coverage, we can provide you with a discounted self-pay rate.

For account balances, we accept checks and credit card payments. Balances due may be applied to your credit card on file if not paid upon billing. 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.**

Signature

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, expenses, and any deductibles that are required pursuant to the above mentioned insurance policy.

If my insurance changes after my initial appointment, it is my responsibility to notify BN immediately and provide a copy of the new insurance card. I agree if I do not notify BN in advance of any change in insurance this could result in me being responsible for my balance.

***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.**

Our pledge to you is that we will do everything possible to be present and prepared for your appointment. We ask for your consideration by giving us at least 24 hours' notice if you need to change an appointment.

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 \$75 charge 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 at 405-755-7561. E-mail and text are not accepted.

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

Signature

Date