BANISTER NUTRITION LLC

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: _____

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Medical History

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

- ❑ Abdominal Surgery
- ❑ Anemia
- ❑ Anxiety
- ❑ Autoimmune Disease
- ❑ Asthma
- ❑ Arthritis
- ❑ Cancer (specify): _____
- ❑ Celiac Disease
- ❑ Chronic Back Pain
- ❑ Congestive Heart Failure
- ❑ Constipation
- ❑ Crohn's Disease
- ❑ Chewing Difficulties
- ❑ Dentures
- ❑ Depression
- ❑ Diabetes
- ❑ Dialysis
- ❑ Diarrhea
- ❑ Disordered Eating
- ❑ Food Allergies
- ❑ Food Sensitivities
- ❑ Gallbladder Disease
- ❑ Gastric Bypass
- ❑ Gout
- ❑ Headaches / Migraines
- ❑ Heart Disease / Heart Attack
- ❑ High Blood Pressure / HTN
- ❑ High Cholesterol
- ❑ High Triglycerides
- ❑ History of Trauma / Abuse
- ❑ Hormone Imbalances
- ❑ Hypoglycemia
- ❑ Heartburn/GERD
- ❑ Immunosuppression
- ❑ Infertility
- ❑ Irritable Bowel Syndrome (IBS)
- ❑ Kidney Disease
- ❑ Kidney Stones
- ❑ Liver Disease
- ❑ Low Energy Level
- ❑ Lung Disease
- ❑ Menstrual Irregularity
- ❑ Nausea/Vomiting
- ❑ Neurological Disease
- ❑ Obesity
- ❑ Osteoporosis / Osteopenia
- ❑ Pancreatitis
- ❑ Psychological Condition
- ❑ Rashes / Skin Problems
- ❑ Recent Hospitalization
- ❑ Recent Infection
- ❑ Sickle Cell Disease
- ❑ Sleep Apnea / Sleep Disorder
- ❑ Stomach Ulcers
- ❑ Swallowing Difficulties
- ❑ Thyroid Disease
- ❑ Urinary Difficulties
- ❑ Other: _____
- ❑ _____
- ❑ _____

Do you have a family history of the following?

- ❑ Cancer
- ❑ Diabetes
- ❑ Heart Disease
- ❑ Gastrointestinal Disorders
- ❑ Obesity
- ❑ Other: _____
- ❑ _____
- ❑ _____
- ❑ _____

Prior Surgeries: _____

_____

_____

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

Name	Dose / Amount	Time	Purpose

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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.)?

_____

_____

_____

BANISTER NUTRITION LLC

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

BANISTER NUTRITION LLC

Assignment of Benefits

***Please disregard this page if you are <u>not</u> 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

BANISTER NUTRITION LLC

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