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

- **If you are interested in seeking payment assistance from your insurance provider, please review all the information cited below.**
- **A copy of your credit card is needed to secure your appointment.**
- **Your health care assistance is based on a choice and agreement you made with your insurance provider. BN has no knowledge of your choices of assistance.**
- **BN works with Aetna, BlueCross BlueShield, Community Care, Coventry, Health Choice, Medicare, Medicaid/SoonerCare and United Health Care.**
- **BN does not participate in any HMO insurance plans.**
- **YOU are responsible for contacting your insurance provider to confirm your benefits for *Medical Nutrition Therapy.* We can provide guidance of points to discuss if you request.**
- **BN will file your insurance for you as a courtesy if you prefer. A provider referral and diagnosis code (ICD-10) from your provider is required to file insurance.**
- ***MEDICARE Assistance:* Your referring provider *must* be a Medicare provider. Medicare covers *Renal Disease, Type 1 & 2 Diabetes only.* We will gladly see all other diagnoses for Medicare patients as *self-pay*.**
- **Medical Nutrition Therapy Fees: 30 min-$100, 60 min-$150, 90 min -$250**
- **BN makes NO guarantee of payment assistance from your insurance company.**
- **You are responsible at time of appointment for ALL fees your insurance does not cover. We accept cash, checks and credit card payments.**

Please sign below acknowledging you accept responsibility for our payment policy. Thank you and we look forward to supporting you on your journey to improved health and fitness. ☺

Patient/Guardian Signature **Date**

8/1/23

BANISTER NUTRITION LLC

Cancellation Policy

- 24 hour advance notice of your need to change your appointment is required. This time is needed to fill your reserved time slot with another patient.

- Requests for appointment changes are only accepted via phone. Emails and texts are not checked regularly.

- You will be notified of the $75-$150 charge to your credit card for late cancellation

Please sign below acknowledging you accept responsibility for our cancellation policy. Thank you and we look forward to supporting you on your journey to improved health and fitness. ☺

Patient/Guardian Signature **Date**

Thank you for understanding our desire to accommodate all patients to be seen as soon as possible.

8/1/23

BANISTER NUTRITION LLC

Assignment of Benefits

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 timely manner, any balance of medical charges and expenses over and above the amount of 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.

Patient/Guardian Signature **Date**

HIPAA

Please read Banister Nutrition HIPAA – Notice of Privacy Practice in our office or website at https://banisternutrition.com/new-patients/

Please acknowledge by signing below, that you have read the HIPAA and understand your rights according to the HIPAA.

Patient/Guardian Signature **Date**