Tampa Nutrition Therapy, LLC
Provided by Batina Timmons MS, RD, LD/N
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REGISTRATION INFORMATION

First Name_____ Middle_____ Last Name_____

Address_____City_____ST____Zip_____

E-mail_____ BIRTHDATE____/____/_____ AGE_____

PHONE (H)_____ Work_____ Cell_____

Primary Doctor_____ PCP Phone_____
Specialty Doctor_____ Phone_____

How were you referred?_____
Your EMPLOYER_____ OCCUPATION_____

PRIMARY INSURANCE / MEDICARE

Policy Holder NAME_____ Policy Holder SS#_____
Policy No._____ Group No._____

SECONDARY INSURANCE / MEDICARE

Policy Holder NAME_____ Policy Holder SS#_____
Policy No._____ Group No._____

If you can't make your appointment, please let us know as soon as possible so we can offer it to someone else. If you miss your appointment or cancel with less than 24 hours' notice and we cannot re-allocate appointment slot, 100% of the fee becomes payable. WE reserve the right to charge for missed appointments.

Please note, you do not have to indicate your doctors phone number if you do not want us to contact them. We consider it a courtesy to let your doctor know that you are receiving medical nutrition therapy.

If someone other than the client is completing this form, please provide proof of authority to do so, in the form of a power of attorney or guardianship document.

RESPONSIBILITY FOR PAYMENT

I, _____, understand that I may be billed for services rendered if Medicare fails to assign payment despite prior approval of services. I agree to be fully and personally responsible for payment.

Signature or initials of patient or authorized representative_____

AGREEMENT TO MAINTAIN SIGNATURE ON FILE FOR COMMUNICATIONS WITH MEDICARE

Signature or initials of patient or authorized representative_____

I HEREBY,

I. CERTIFY THAT I HAVE RECEIVED A COPY OF THE HIPAA PRIVACY NOTICE

II. AUTHORIZE MEDICARE PAYMENTS TO BE SENT TO TAMPA NUTRITION THERAPY IF APPLICABLE

III. CERTIFY THAT I AM FINANCIALLY RESPONSIBLE FOR ALL SERVICES RENDERED TO ME AND/OR MEMBERS OF MY FAMILY. IF MEDICARE FAILS TO ASSIGN PAYMENT OR IS NOT APPLICABLE; I CERTIFY THAT PAYMENT WILL BE MADE WITHIN 30 DAYS

IV. I CERTIFY THAT I HAVE RECEIVED AND AGREE TO THE PATIENT POLICIES

V. I CERTIFY THAT I WILL BE RESPONSIBLE FOR A $15.00 LATE FEE ON COPAYMENTS NOT PAID AT THE TIME OF SERVICE, AN ADDITIONAL 50% OF PAYMENT DUE IF DELINQUENT BY 45 DAYS IN ADDITION TO THE COST OF COLLECTION FEES. 100% OF VISIT WILL BE CHARGED FOR APPOINTMENTS NOT CANCELLED WITHIN 24 HOURS OF VISIT

SIGNATURE_____DATE_____

CLIENT DATA SHEET

PLEASE COMPLETE THE FOLLOWING QUESTIONS:

WHAT ARE YOUR PERSONAL NUTRITION GOALS

_____

Have you ever worked with a dietitian/nutritionist?_____ If yes, who?_____

HEALTH STATISITICS:

HEIGHT_____ WEIGHT_____USUAL WEIGHT_____GOAL WEIGHT_____

Any significant weight changes over the past 6 months?_____

Do you have any food allergies / intolerances?_____

PAST MEDICAL HISTORY including major illness and surgeries_____

_____

_____

MEDICATIONS_____

_____

VITAMIN MINERAL SUPPLEMENTS & HERBAL PREPARATIONS_____

Who does the cooking?_____ shopping?_____

What are your favorite foods?_____

Do you smoke?_____ If yes, how many per day?_____

Do you drink alcohol?_____ If yes, what kind & how often?_____

Do you exercise?_____, If so, what, how long & how often?_____

Put an X on the line below to show, on a scale from 0 to 10, how you rate your knowledge level regarding general nutrition?

……

0	5	10
I don't know anything	I know the basics	I am an expert

How would you rate the application of your nutrition knowledge to your everyday lifestyle?

……

0	5	10
I never eat healthy	I eat healthy 3 times per week	I eat healthy daily

Put an X on the line below to show, on a scale from 0 to 10, how important it is for you to make lifestyle changes? (Lifestyle changes are changes to improve your health, such as

adjusting your diet, increasing your physical activity, and changing health-related behaviors.)

……

0	5	10
Not very important	Somewhat important	Very important

Put an X on the line to show how ready you are right now, on a scale of 0 to 10, to make lifestyle changes.

……

0	5	10
Not very ready	Somewhat ready	Very ready

Put an X on the line to show how confident you are, on a scale of 0 to 10, that you can make lifestyle changes?

……

0	5	10
Not very confident	Somewhat confident	Very confident

What lifestyle changes would you be willing to make?

_____

How much time would you be willing to spend each week on making lifestyle changes? (for example, attending classes, reading info, tracking foods eaten and activity)

_____

What barriers or obstacles will challenge you in reaching your goal?

___ Lack of nutrition knowledge

___ Lack of time/hectic schedule

___ Lack of organization

___ Don't like to cook

___ Don't know how to cook

___ Emotional eating (overeating or not eating enough due to stress, boredom, anxiety, loneliness, being scared, sad, happy/relaxed)

___ Other: _____

Put an X on the line to show your current level of stress, on a scale of 1 to 5.

……

1	3	5
Very relaxed	Managing OK	Very stressed

Describe your family- number of people who live with you and their relationship to you.

- ❑ Husband, wife, or partner
- ❑ Children--- How many? _____, Ages _____
- ❑ Other--- Describe:_____

Do you feel you have a good support system to help you accomplish your goals?

_____

Check any that apply:

- ❑ My family eats most meals together.
- ❑ Family meals are served at regular times on most days.
- ❑ Another member of my family is on special diet or is trying to lose weight. Describe._____

Check the type of food you and your family eat and how many times in a typical week:

- ❑ Heat and serve meals _____
- ❑ Home-cooked meals _____
- ❑ Fast foods _____
- ❑ Take out _____
  (Grocery or Restaurant)

After completing this health and nutrition history, what is your most important goal you want nutrition counseling to help you reach?

_____

_____

24-Hour Diet Recall

Please be as specific as possible. Include all beverages, condiments, and snacks.

Food	Amount Be specific (1 slice, 2 oz., ½ cup)	Time Food Consumed

For RD use only

IBW_____ %IBW_____ ABW_____BMI_____

KCAL Needs_____ / _____kcals/kg

Prot. Needs _____ / _____g/kg

PRACTICE POLICIES

In order to meet your needs and provide you the best possible care, please honor the following guidelines:

1. Please respect your Nutrition Therapists appointment **time limits** and be aware that initial appointments typically last from 60-75 minutes in length; follow up visits last 30 minutes. Client visits are typically scheduled one right after the other.
2. You must **have your doctor send a referral** prior to your first visit if you are a Medicare patient. Referrals must include your diagnosis, number of visits required, the doctor's full name and UPIN number.
3. You must have **your Medicare card** available on your first visit and make available any new cards as you may receive them.
4. You must pay your co-pay or 20% of services if no secondary insurance is maintained. **You may pay cash, check or money order only made payable to Batina Timmons or Tampa Nutrition Therapy.**
5. All outstanding balances will be billed to you. Late fees will be incurred after 45 days. Your account will be sent to collection if not received in 45 days and will include any collection fees and late fees you have incurred.
6. A $15.00 late fee will be charged on co-payments not paid at the time of service. An additional 50% will be added to your balance if payment is delinquent by 45 days in addition to the cost of any collection fees. For all clients, the entire visit fee will be charged for appointments not cancelled within 24 hours of visit or no shows.
7. You must complete and sign a **Patient Registration Form** with accurate information including that of your spouse or parent if they

are the policy holder. Please print and complete the Registration documents prior to the first visit.

8. Please record the date and time of your appointment. **You will be charged the full amount of your visit if you miss your appointment or if you do not cancel your appointment 24 hours in advance.**
9. Bring copies of your most recent lab values or ask your doctor to fax them prior to your first visit.

HIPPA STATEMENT
Notice of Privacy Practices

Keeping our client's personal health information secure is a top priority. This notice describes how we collect, handle, and disclose personal health information about you.

Our Policies and Practices to Protect Your Personal Health Information

We are required by law to:

- Protect your medical information
- Give you this notice describing our legal duties and privacy practices with respect to medical information about you

Collection of protected health information:

- Information is received from your physician or other healthcare provider
- Information we receive from you while providing MNT services and from assessment and registration forms
- Information we receive from other sources such as a caregiver, insurer, employer, family member and other third parties involved directly with your care

How we may use and disclose your medical information:

- We may use your medical information in providing you with medical nutrition therapies

- We may disclose your information to doctors, hospitals, nurses, pharmacies, insurance companies, health care providers directly involved in your individual care
- We may disclose your information in response to a subpoena, warrant or other lawful process, criminal activity or an emergency

Protected health information will not be used for marketing

HIPPA PRIVACY AND PROCEDURE REQUIREMENTS HAVE BEEN EXPLAINED TO ME AND I HAVE READ AND UNDERSTAND THE FOLLOWING STATEMENT

Signature_____ Date_____