PREFERRED NUTRITION

PATIENT REGISTRATION

Name: _____ Date: _____ DOB: _____ M F

Address: _____ City:_____ State: _____ Zip: ___

Home Phone: _____ Cell/Work Phone: _____

Email: _____ Preferred Communication: Phone Email

Can we leave a message? If yes, preferred number: _____

Referred by: _____

INSURANCE INFORMATION

Subscriber Name: _____ DOB: _____

Relationship to Patient: _____

Insurance Provider: _____ Phone Number: _____

Member ID: _____ Group Number: _____

Other: _____

2380 S. 3rd Street, Suite 1
Jacksonville Beach, FL 32250
Phone (904) 270-1234

PREFERRED NUTRITION

AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, date of birth, __/___/____, hereby authorize Preferred Nutrition Services to discuss my/my child's progress, release medical records and/or progress notes for the purpose of nutrition assessment and therapy with/to the following individuals:

PHYSICIAN:

Name: _____

Address:_____

Phone/Fax: _____

THERAPIST:

Name: _____

Address:_____

Phone/Fax: _____

OTHER:

Name: _____

Address:_____

Phone/Fax: _____

I agree that a photocopy of this release form is acceptable, and I understand that I have the right to receive a copy of the authorization form upon my request. I may revoke the consent to release information at any time. I also understand that any release of information which has been made before any revocation and which is based upon this authorization, shall not constitute a breach of my right of confidentiality.

_____ _____

Signature of client/guardian Printed Name

_____ _____

Authorization Date Witness

Relationship to Client: ___Self ___Guardian ___Parent of minor ___Person legally authorized on client's behalf

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PREFERRED NUTRITION

FINANCIAL AGREEMENT

Client: _____Date: _____

Guarantor: _____

Guarantor Address (if different from client): _____

_____

_____ *Initial* I understand that my insurance _____may not cover nutrition counseling/medical nutrition therapy at Preferred Nutrition Services at this time. I understand Preferred Nutrition may bill me for services rendered upon denial of my insurance company/Medicare—despite prior approval. I agree to be fully and personally responsible for payment.

_____ *Initial* I accept full financial responsibility for services provided and understand that the fee for the Medical Nutrition Services provided is due upon receipt of the service. There is $20.00 fee for returned checks. Fees are listed below and may be adjusted to reflect financial need:

- Medical Nutrition Therapy: 1 hour - $120
- Group sessions: 1 hour - $30
- Phone Consultation/Email correspondence: half hour - $60

_____ *Initial* I agree to kindly give 24 hour notice if my appointment needs to be rescheduled. 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 hour notice we cannot re-allocate that appointment slot, therefore there is a $50.00 fee for a missed appointment.

_____ _____

Patient/Guardian Signature *Date*

PAYMENT METHOD

Cash Check Visa MasterCard Other_____

Credit Card Number _____ Expiration Date: _____

Name of Cardholder: _____ CVV Code _____

I understand that this form authorizes my provider to charge this card for varying session types, across multiple dates of service. By authorizing use of this card, and signing this payment authorization form, I certify that I am the cardholder and my signature below authorizes each charge for all dates of service.

_____ _____

Cardholder Signature Date

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HIPAA NOTICE

- I understand that my/my child's Medical Nutrition Therapy will be confidential to all but those who I have given authorization to, in accordance to federal HIPAA guidelines. A copy of the Preferred Nutrition policy is available and I may request a copy if I desire. I also understand that the Registered Dietitians of Preferred Nutrition Services operate under the highest ethical standards of the Academy of Nutrition & Dietetics.

- I understand email correspondence poses a risk on the internet and content may be read by others out of our control. We maintain antivirus software on our computers and make every effort to keep your information private.
  - Periodically we send out nutrition news information via email, however we do NOT give out or sell your email address to other parties.
    _____Yes, I would like to receive your monthly newsletter and updates.
    _____No, please do not add me to your newsletter list at this time.

- I request that payment of authorized Insurance/Medicare benefits be made either to me or on my behalf to Preferred Nutrition Services for any services furnished to me by that provider. I authorize any holder of medical information about me to release to the Insurance/Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits or the benefits payable for related services.

- Medigap Policy holders only: I request the payment of authorized Medigap benefits be made either to me or on my behalf to Preferred Nutrition Services for any services furnished to me by that provider. I authorize any holder of medical information about me to release to _____(Medigap insurer) any information needed to determine these benefits or the benefits payable for related services.

_____ _____

Patient (or authorized representative/guardian) Signature Date

Relationship to Client: ___Self ___Guardian ___Parent of minor ___Person legally authorized on client's behalf

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EATING ATTITUDES TEST (EAT-26)

Height _____
Current Weight _____
Highest Weight (excluding pregnancy) _____
Lowest Adult Weight _____
Do you participate in athletics at any of the following level:

O Intramural
O Inter-Collegiate
O Recreational
O High School teams

	Always	Usually	Often	Sometimes	Rarely	Never	Score
1. Am terrified about being overweight	O	O	O	O	O	O	___
2. Avoid eating when I am hungry	O	O	O	O	O	O	___
3. Find myself preoccupied with food	O	O	O	O	O	O	___
4. Have gone on eating binges where I feel that I may not be able to stop	O	O	O	O	O	O	___
5. Cut my food into small pieces	O	O	O	O	O	O	___
6. Aware of the calorie content of foods that I eat	O	O	O	O	O	O	___
7. Particularly avoid foods with a high carbohydrate content (i.e. bread, rice, potatoes, etc.)	O	O	O	O	O	O	___
8. Feel that others would prefer if I ate more	O	O	O	O	O	O	___
9. Vomit after I have eaten	O	O	O	O	O	O	___
10. Feel extremely guilty after eating	O	O	O	O	O	O	___
11. Am preoccupied with a desire to be thinner	O	O	O	O	O	O	___
12. Think about burning up calories when I exercise	O	O	O	O	O	O	___
13. Other people think that I am too thin	O	O	O	O	O	O	___
14. Am preoccupied with the thought of having fat on my body	O	O	O	O	O	O	___
15. Take longer than others to eat my meals	O	O	O	O	O	O	___
16. Avoid foods with sugar in them	O	O	O	O	O	O	___
17. Eat diet foods	O	O	O	O	O	O	___
18. Feel that food controls my life	O	O	O	O	O	O	___
19. Display self-control around food	O	O	O	O	O	O	___
20. Feel that others pressure me to eat	O	O	O	O	O	O	
21. Give too much time and thought to food	O	O	O	O	O	O	
22. Feel uncomfortable after eating sweets	O	O	O	O	O	O	
23. Engage in dieting behavior	O	O	O	O	O	O	
24. Like my stomach to be empty	O	O	O	O	O	O	
25. Enjoy trying new rich foods	O	O	O	O	O	O	
26. Have the impulse to vomit after meals	O	O	O	O	O	O	

Total Score (see below for scoring instructions) _____

EAT-26 David M. Garner & Paul E. Garfinkel (1979), David M. Garner et al., (1982)

PLEASE RESPOND TO EACH OF THE FOLLOWING QUESTIONS:

1) Have you gone on eating binges where you feel that you may not be able to stop? (Eating much more than most people would eat under the same circumstances)

No O Yes O How many times in the last 6 months? _____

2) Have you ever made yourself sick (vomited) to control your weight or shape?

No O Yes O How many times in the last 6 months? _____

3) Have you ever used laxatives, diet pills or diuretics (water pills) to control your weight or shape?

No O Yes O How many times in the last 6 months? _____

4) Have you ever been treated for an eating disorder?

No O Yes O When? _____

5) Have you recently thought of or attempted suicide?

No O Yes O When? _____

SCORING THE EATING ATTITUDES TEST

For all items **except #25**, each of the responses receives the following value:

Always = 3
Usually = 2
Often = 1
Sometimes = 0
Rarely = 0
Never = 0

For **item #25**, the responses receive these values:

Always = 0
Usually = 0
Often = 0
Sometimes = 1
Rarely = 2
Never = 3

- After scoring each item, add the scores for a total. If your score is over **20**, we recommend that you discuss your responses with a counselor (take your responses to the EAT with you to your first appointment).

- If you responded yes to any of the five YES/NO items on the bottom of the EAT, we also suggest that you discuss your responses with a counselor.