Dietitian on a Mission, LLC

NEW PATIENT FORM

Today's Date: _____

GENERAL PATIENT INFORMATION

Patient Name | DOB (MM/DD/YYYY) | Age | Sex

Address | City | State | Zip

Home Phone | Cell Phone | Work Phone

Email

Preferred Contact Method (Please circle all that apply):
Home Phone Cell Phone Work Phone Email

Social Security Number | Marital Status

Spouse/Partner/Parent/Guardian Name (circle one) | DOB (MM/DD/YYYY) | Age | Sex

Social Security Number | Home Phone | Cell Phone

Emergency Contact | Phone Number | Relationship

Employer | Title/Position

School Currently Enrolled In (write "N/A" if not applicable) | Highest Level of Education Completed

How did you hear about Brittany Hunter RD/LD?

☐ Internet Search ☐ Family Member/Friend
☐ Insurance Provider ☐ Previous Patient
☐ Other, please specify: _____
☐ Referred by Another Clinician:

Name of Clinician | Name of Facility | Phone

Address | City | State | Zip

NEW PATIENT FORM

INSURANCE INFORMATION

Insurance Provider | Phone Number | ID Number | Group Number

Provider Address | City | State | Zip

Policy Holder | Relationship | DOB (MM/DD/YYYY)

Policy Holder Address | City | State | Zip

Employer/School Name (circle one) | Phone Number

Employer Address | City | State | Zip

Signature of Patient or Guardian | Date

NEW PATIENT FORM

Health History

Date: _____

DOB: _____

Name *(Last, First, M.I.):* ¨ M ¨ F

Marital status: ¨ Single ¨ Partnered ¨ Married ¨ Separated ¨ Divorced ¨ Widowed

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Previous or referring doctor:

Date of last physical exam:

Personal Health History

List any medical problems that other doctors have diagnosed		
Other hospitalizations		
Year	Reason	Hospital
List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the drug	Strength	Frequency taken

NEW PATIENT FORM

Allergies/Reaction to medications		
Name the drug	Reaction you had	

24 hour recall

Include everything you ate, drank and did from the time you woke up

Time	Food/Beverage	Amount

NEW PATIENT FORM

Are weekends different from weekdays? If so, take me through your weekend?

Time	Food/Beverage	Amount

NEW PATIENT FORM

Please list all exercise done in the last week, including length and intensity of each activity. If needed, please use space below to elaborate.

- I did not exercise over the last week.

EXERCISE ACTIVITY /LENGTH /INTENSITY /TIME OF DAY

Example: Running 5 miles in 35 min. Moderate 7 a.m.

Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	
Sunday	

PAYMENT POLICIES

NEW PATIENT FORM

For Dietitian on a Mission LLC accepts Cash Pay. For patients who carry a qualifying form of insurance, a Superbill will be given to the patient to send to the insurance company to request reimbursement. Reimbursement is not guaranteed and may cover some or all of the services rendered. For Dietitian on a Mission LLC, payment will be due in full at each visit for service rendered. One hour sessions are $100.00 and half hour sessions are $60.00. The first two sessions are for meal planning and assessment and will be one hour in length. After the first two visits, the sessions can be half to one full hour depending on each individual client.

We accept cash or check. For more information, please either call our office at (405) 242-5305 or email us at Brittany@Familysolutionsok.com.

MISSED APPOINTMENTS:

We have a limited number of appointments available and each one is scheduled to take at least an hour of Brittany Hunter RD/LD. Therefore, we ask that **if you must reschedule or cancel an appointment, you notify us 24 business hours prior to your scheduled appointment time.** Failure to do so will result in a **$100.00 charge**. A **"No Call No Show"** to a scheduled appointment will also result in a **charge in the amount of $100.00** and will be due upon receipt. Of course, we do make exceptions for emergencies, which is determined by our office.

RETURNED CHECK POLICY:

Should you decide to pay in the form of a check and it is returned to our office unable to process payment, a **$25.00 fee** will be applied to the patient's file. At future appointments, cash will be the only forms of payment accepted.

By signing below, I admit that I have read and agree to the policies stated above in regard to payment for any treatment or services provided to me by for Dietitian on a Mission LLC.

_____

Patient's Printed Full Name

_____ _____

Signature of Patient/Patient's Guardian Date

Dietitian On A Mssion, LLC
MEDICAL CONFIDENTIALITY AGREEMENT/HIPAA FORM

This medical agreement is signed on _____, and the parties involved are Brittany Hunter RD/LD Dietitian on a Mission LLC and _____ (patient).

NEW PATIENT FORM

Details of Dietitian on a mission, LLC and Brittany Hunter RD/LD:

Name: Brittany Hunter RD/LD, Dietitian on a Mission LLC

Clinic Address:

Designation: Registered Dietitian and Eating Disorder Specialist

Contact: (405) 550-2899

Details of the Patient:

Name: _____

Address: _____

Contact: _____

If you would like us to speak with anyone other than yourself concerning your medical condition, please list them below. If you do not want us to speak with anyone other than yourself about your medical condition, please leave blank.

Name 1: _____

Address: _____

Contact: _____

Name 2: _____

Address: _____

Contact: _____

_____ I agree to allow medical records to be released to my insurance company as needed to file insurance claims on my own behalf.

_____ I do not agree to allow medical records to be released to my insurance company as needed to file insurance claims on my own behalf.

Both Parties involved hereby agree to the following terms and conditions:

I. for Dietitian on a Mission LLC , agree to keep all the medical records and history, medication details and other confidential information within its/her reach and not to be shared with anyone, unless listed above.
II. The patient agrees to hold for Dietitian on a Mission LLC responsible in case of any misconduct or leakage of the confidential information.

Signed by: _____ (patient) Date: _____

Signed by: _____ (provider) Date: _____

AUTHORIZATION FOR RELEASE/REQUEST OF PROTECTED HEALTH INFORMATION

Dietitian on a Mission, LLC

NEW PATIENT FORM

Patient's Name: _____ Date: _____

Date of Birth: _____/_____/_____ Medical Record Number: _____

I hereby authorize for Dietitian on a Mission LLC **to release/receive information from:**

Contact Name: _____ Relationship to Patient: _____

Contact Facility/Practice/Other: _____

Contact Address: _____

Home Phone: _____ Cell Phone: _____ Business Phone: _____

Fax: _____ Email: _____

Purpose for release of information: _____ Continuity of Care

_____ Other: _____

I understand that my treatment records are protected under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). 45 C.F.R. parts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows: One year from date of the patient's signature on this form.

"Federal Regulation (42 C.F.R. Part 2) prohibits any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to who it pertains, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal Rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient."

Treatment services are not contingent upon or influenced by the patient's decision to permit the information release.
The information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.

My initials below signify that I consent for the following types of information to be released to the above individual/entity:

_____ 1. Drug/alcohol abuse, which is protected by Federal Regulations

_____ 2. Psychological or psychiatric conditions

_____ 3. Medical Tests including labs, x-rays, imaging, etc.

_____ 4. HIV or AIDS related records

_____ 5. Family and/or social history

_____ 6. Medical History

Restrictions (if any):

_____

_____ _____ _____ _____

Patient Signature Date Parent/Guardian/Authorized Representative Signature Date

Revocation: I hereby revoke the above authorization.

_____ _____ _____ _____

Patient Signature Date Parent/Guardian/Authorized Representative Signature