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 Sanders 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

I hereby authorize Meghan Scears, MD, PLLC to provide information to insurance carriers concerning this illness as required by the insurance carrier and as defined in the previously provided paperwork outlining Meghan Scears, MD, PLLC and office policies and procedures.

I understand that for Dietitian on a Mission LLC **C will, as a courtesy, file claims with insurance carriers. However, I acknowledge and agree, except as provided by law, and in consideration of the service provided, that I will pay any charges which for any reason are not paid by any third party payer unless there is a specific written agreement between** for Dietitian on a Mission LLC **and the patient and payer.**

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

	Physical and/or mental abuse have also become major public health issues in this country. This often takes the form of verbally threatening behavior or actual physical or sexual abuse. Would you like to discuss this issue with your provider?	☐ Yes	☐ No

Family Health History					
Age Significant Health Problems including eating disorders					
Father			Children	☐M ☐F	
Mother				☐M ☐F	
Sibling	☐M ☐F			☐M ☐F	
	☐M ☐F			☐M ☐F	
	☐M ☐F		Grandmother *Maternal*		
	☐M ☐F		Grandfather *Maternal*		
	☐M ☐F		Grandmother *Paternal*		
	☐M ☐F		Grandfather *Paternal*		

Women Only		
Age at onset of menstruation:		
Date of last menstruation:		
Period every _____ days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies _____ Number of live births _____		
Are you pregnant or breastfeeding?	☐ Yes	☐ No

NEW PATIENT FORM

Personal and Family History:

Current occupation or student status: _____

Ranking in occupation or as student: _____

Satisfaction in occupation or as student: _____

Marital status: _____

Satisfaction with marital status _____

If married, spouse occupation: _____

Number and ages of children:

Child 1: _____ Child 2: _____ Child 3: _____

How do you rate your capabilities as a mom? ____poor ____fair ____good ____great

If single, what is your living arrangement?

Apartment on own

Apartment with roommate

Home with parent(s)

Home with relative other than parent(s) housing and number in household

If parents are divorced, age of client at time of divorce: _____

If siblings, number and sex of siblings:

Sibling 1: _____ Sibling 2: _____

Sibling 3: _____

Is there anyone in the family with: weight problems an eating disorders, or any other illness (mental or physical) List:

_____

_____

NEW PATIENT FORM

EXERCISE HISTORY:

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	

NEW PATIENT FORM

For patients who carry a qualifying form of insurance, Dietitian on a Mission, LLC will send the service to your 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. The first two sessions are for meal planning and assessment. One-hour sessions are $120.00.

MISSED APPOINTMENTS:

We have a limited number of appointments available and each one is scheduled to take at least an hour of Brittany Sanders 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 **$50.00 charge**. A **"No Call No Show"** to a scheduled appointment will also result in a **charge in the amount of $50.00** 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

NEW PATIENT FORM
Dietitian On A Mssion, LLC
MEDICAL CONFIDENTIALITY AGREEMENT/HIPPA FORM

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

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

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

Clinic Address: 10400 N Vineyard Blvd OKC OK 73120

Designation: Registered Dietitian and Eating Disorder Specialist

Contact: (405) 550-2899

Details of the Patient:

Name: _____

Address: _____

Contact: _____

Family release: 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: _____

_____ I agree to allow medical records to be released to my insurance company as needed for Dietitian on a Mission LLC to file insurance claims on my behalf.

_____ I do not agree to allow medical records to be released to my insurance company as needed for for Dietitian on a Mission LLC to file insurance claims on my 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: _____

Dietitian on a Mission, LLC

NEW PATIENT FORM
AUTHORIZATION FOR RELEASE/REQUEST OF PROTECTED HEALTH INFORMATION

Other Providers/TREATMENT TEAM

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: _____

Business Phone: _____ Fax: _____Email: _____

Contact Name: _____ Relationship to Patient: _____

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 ("HIPPA"). 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