SHS Nutrition, LLC

Registration Form

Patient Information:

Patient's Name: _____ Date: _____/_____/_____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____-_____-_____ Cell Phone: _____-_____-_____

Email Address: _____

Date of Birth: _____/_____/_____ Age: _____

Occupation: _____ Employer: _____

Insurance Information:

Primary

Insurance Company: _____ ID: _____

Primary Insured's Name: _____

Primary Insured's Date of Birth: _____/_____/_____ Relationship to Insured: _____

Secondary (if applicable)

Insurance Company: _____ ID: _____

Secondary Insured's Name: _____

Secondary Insured's Date of Birth: _____/_____/_____ Relationship to Insured: _____

Physician Information:

Primary Physician

Name: _____ Phone: _____-_____-_____

Address: _____

City: _____ State: _____ Zip Code: _____

Referring Physician

Name: _____ Phone: _____-_____-_____

How did you hear about SHS Nutrition?_____

_____

Insurance Payment and Release of Information Authorization

Patient's Name: _____

Insurance Company: _____

Insurance ID: _____

I, _____, authorize payment of medical benefits to SHS Nutrition, LLC for services furnished to me by them. Additionally, I authorize the release of any medical or other information necessary to process claims for medical benefits. I understand that regardless of my insurance coverage, I am responsible for the payment of all fees for services rendered to me. If, for any reason, any fees are not paid by my insurance company, I understand that the following fees must be paid by me: $175.00 for the initial appointment, $65.00 for every 30 minute follow-up appointment, and $125.00 for every 60 minute follow-up appointment. When applicable, I will render co-payments, co-insurance payments, and deductibles at or after the time of service. Once the service is provided, there are no refunds or credits given.

I am fully responsible for paying SHS Nutrition, LLC all of the amounts my insurance company states are being applied to amounts in excess of benefit and lifetime maximums, coinsurance, coordination of benefits, copays, deductibles, pre-existing conditions clauses, and the like. Medical notes that are created by the registered dietitian after the appointment will not be submitted to the appropriate doctor until I have paid off the full amount that I am responsible for the visit.

I am fully responsible for paying the full billed charge if the following cases: (1) I fail to obtain any referrals required by my insurance company or (2) My insurance changes or terminates and I fail to notify SHS Nutrition, LLC prior to any services being rendered.

Failure to pay a bill sent to me within 30 days of the date of the invoice will result in a $20.00 late payment fee. Any payments made directly to me or my dependents owing to SHS Nutrition, LLC will be remitted immediately, payable to "SHS Nutrition, LLC".

I understand that I will be fully responsible for the payment of any attorney fees, collection costs, and court costs that SHS Nutrition, LLC incurs to collect the amounts owed.

_____ _____/_____/_____

Patient's Signature Date

Confirmation of Receipt of Privacy Notice

I have received and reviewed SHS Nutrition, LLC's Health Insurance Portability and Accountability Act (HIPAA) Privacy Notice*.

_____ _____/_____/_____

Patient's Signature Date

*SHS Nutrition, LLC's HIPAA Privacy Notice can be found on www.shsnutrition.com/patient-forms/.

No Show Policy

SHS Nutrition, LLC will charge you a $60.00 no show fee in the following cases: (1) Your appointment is not cancelled within 24 hours of your scheduled appointment time.* (2) You confirm for your appointment but do not show to your appointment.** No appointments scheduled by SHS Nutrition, LLC will be double-booked. It is appreciated when you inform SHS Nutrition, LLC of any needed cancellations before your appointment time. If for any reason you have to cancel your appointment, please contact SHS Nutrition, LLC as soon as possible using one of the following forms of communication: email (appointments@shsnutrition.com), phone call (732-395-1282), or text message (732-395-1282).

If there is a no show fee on your account, you will be unable to schedule another appointment with SHS Nutrition, LLC until the no show fee is paid. Once the no show fee is paid, the services rendered to you can resume. The fee can be paid either over the phone with a credit or debit card (732-395-1282) or by mail with a check payable to "SHS Nutrition, LLC".

I have read SHS Nutrition, LLC's no show policy and will be fully responsible for the payment of any no show fees that are charged to my account.

_____ _____/_____/_____

Patient's Signature Date

*For example, a patient has an appointment at 3:00pm on October 21st. A no show fee will not be charged if the appointment is cancelled before 3:00 on October 20th. If the appointment is cancelled between 3:00pm on October 20th and 3:00pm on October 21st, the patient will be charged a $60.00 no show fee.
**A no show fee charged in this case is at the discretion of Sara Shama, R.D. and Ann Espinoza, R.D..

Patient's Medical History and Lifestyle

Name:_____ Date:_____/_____/_____

General

When was the date of your last blood test? _____/_____/_____

Please provide a copy of the lab results or have your physician send us a copy.

Please provide the details of all medications, vitamins, remedies, herbal supplements, and the like that you are currently taking:

Name	Start Date	Dosage	How Often	Reason for Taking

List any allergies and/or reactions to any medications, foods, or other substances: _____

_____

_____

_____

Are you lactose intolerant? ☐ Yes or ☐ No

Are you on a fluid restricted diet? ☐ Yes or ☐ No

Do you have difficulty chewing or swallowing food? ☐ Yes or ☐ No

Please tell us about any other dietary restrictions: _____

_____

Have you experienced any recent: ☐ Abnormal weight gain ☐ Abnormal weight loss

Medical History

Do you have any of the medical conditions listed below? Please check all that apply:

☐ Anemia: Iron or B12	☐ Angioplasty	☐ Anorexia	☐ Arthritis	☐ Asthma
☐ Bariatric Surgery: Gastric Bypass, LapBad, Gastric Sleeve	☐ Bulimia	☐ Cancer	☐ Celiac Disease	☐ Depression, Anxiety
☐ Diabetes: Type 1 or Type 2	☐ Fibromyalgia	☐ Gallstones	☐ GERD	☐ Gout
☐ Heart Attack	☐ Heart Bypass Surgery	☐ Heart Disease	☐ High Blood Pressure	☐ High Cholesterol
☐ High Triglycerides	☐ Hyperthyroid	☐ Hypothyroid	☐ IBS	☐ Kidney Stones
☐ Liver Disease	☐ Lung Disease	☐ Multiple Sclerosis	☐ Osteoporosis	☐ Pacemaker
☐ PCOS	☐ Renal Disease	☐ Sleep Apnea	☐ Stroke	☐ Ulcer

Has your father, brother, or son died before the age of 55 from heart related problems? ☐ Yes or ☐ No

Has your mother, sister, or daughter died before the age of 65 from heart related problems? ☐ Yes or ☐ No

Are any members of your immediate family overweight or obese? ☐ Yes or ☐ No

If so, who (father, mother, brother, sister, child): _____

Have you or any of your family members had bariatric surgery? ☐ Yes or ☐ No

If yes, who and which surgery did they have? _____

_____

In your mind, do you feel that they were successful? ☐ Yes or ☐ No

If no, why? _____

_____

Are you considering bariatric surgery? ☐ Yes or ☐ No

If you have diabetes, how do you control it?

☐ Use diet ☐ Use insulin injections ☐ Use oral medications ☐ Don't control it

What is your fasting glucose level? ☐ _____ or ☐ don't know

What is your Hba1c level? ☐ _____ or ☐ don't know

Substance Abuse

How much do you smoke?

Cigarettes: ____ packs a day for _____ years

Other (please list): _____ _____ times per week

How long ago did you quit? _____ years and _____ months

On average, how much do you drink (provide the number of drinks per week)?

Beer:_____ Wine:_____ Liquor:_____

How often do you take recreational or prescription drugs at a frequency greater than that recommended by your physician? _____

_____

Mental Health

Which are significant sources of stress in your life?

☐ Family Relationships ☐ Health Problems ☐ Housing ☐ Legal Problems

☐ Money Problems ☐ Work Problems ☐ Other (Describe: _____)

What do you do to relieve stress? _____

_____

How often would you characterize your stress level as being high?

☐ Never ☐ Rarely ☐ Sometimes ☐ Often ☐ Usually ☐ Always

Do you ever do the following?

I turn to food when I am stressed or upset. ☐ Yes or ☐ No

I think about food a lot. ☐ Yes or ☐ No

I feel out of control with my eating. ☐ Yes or ☐ No

I binge eat. ☐ Yes or ☐ No

I eat when I am not physically hungry. ☐ Yes or ☐ No

Food helps me deal with my feelings. ☐ Yes or ☐ No

I feel in control when I restrict my eating. ☐ Yes or ☐ No

I feel depressed. ☐ Yes or ☐ No

I feel anxious. ☐ Yes or ☐ No

Do you currently see a therapist? ☐ Yes or ☐ No

If yes, please provide the name and contact information:_____

_____

Do you have any other medical conditions that you would like to tell us about? _____

_____

_____

Please describe your present weight:_____

How satisfied are you with the way you look at this weight? _____

_____

How much do you weigh now? _____

How much did you weigh: 3 months ago:_____ 6 months ago:_____ 1 year ago:_____

What is your lowest adult body weight? _____

How old were you? _____ years old

What is your highest adult body weight? _____

How old were you? _____ years old

What do you think are some of the factors that contribute to your weight? _____

_____

_____

At what weight have you felt your best or you think you would feel your best? _____

How much weight would you like to: ☐ Lose:_____ or ☐ Gain:_____

Do you feel your weight affects your daily activities? ☐ Yes or ☐ No

If yes, how so? _____

_____

What weight loss, fitness, or lifestyle programs have you tried in the past? _____

_____

_____

_____

What usually goes wrong with your weight-loss or lifestyle change programs?_____

_____

_____

_____

From 1 to 10, how committed are you to making a change? _____

What are some potential obstacles that may get in the way of your success? _____

_____

_____

_____

In the last month, how many times did you exercise? _____

Do you currently belong to a gym? ☐ Yes or ☐ No

If yes, what is the name and city it is located in? _____

_____

Women's Health

Are you pregnant? ☐ Yes or ☐ No

Are you perimenopausal or menopausal? ☐ Yes or ☐ No

Additional Notes: