SHS Nutrition, LLC

Registration Form

Patient Information:

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

Parent's Name: _____

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..

Pediatric Patient's Medical History and Lifestyle

Name:_____ Date:_____/_____/_____

General

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

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

Please provide the details of all medications, vitamins, remedies, herbal supplements, and the like that your child takes:

Name	Start Date	Dosage	How Often	Reason for Taking

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

_____

_____

_____

Does your child follow a special diet related to their health? ☐ Yes or ☐ No

Explain:_____

_____

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

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

Please indicate whether your child or family members have/had any of the following conditions:

Disease/Condition	Child	Family	Relationship/Treatment
Asthma	☐	☐	_____
Cancer	☐	☐	_____
Cardiovascular Disease	☐	☐	_____
Diabetes	☐	☐	_____
Drug Dependency	☐	☐	_____
Food Allergies	☐	☐	_____
Food Intolerances	☐	☐	_____
Headaches	☐	☐	_____
Heart Attack	☐	☐	_____
High Cholesterol	☐	☐	_____
Hypertension	☐	☐	_____
Intestinal Problems	☐	☐	_____
Kidney Disease	☐	☐	_____
Menstrual Problems	☐	☐	_____
Mental Health Issues	☐	☐	_____
Obesity	☐	☐	_____
Osteoporosis	☐	☐	_____
Other:_____	☐	☐	_____

Weight History

Current Body Weight:_____ Height (without shoes):_____

What was your child's lowest weight in the past year? _____

What was your child's highest weight in the past year? _____

Eating Habits and Behaviors

Do you have any concerns related to your child's eating habits? ☐ Yes or ☐ No

If yes, explain:_____

_____

Who decides when your child is finished eating? ☐ Child ☐ Parent ☐ Other

Explain:_____

_____

What is done when your child does not want to eat all or most of the food that is on his/her plate? _____

_____

_____

What is done if your child wants a second serving of food? _____

_____

Who prepares the family's meals and does the grocery shopping? _____

Does your child regularly skip meals? ☐ Yes or ☐ No

How many meals a day per week does your child eat?

☐ Breakfast: _____ ☐ Lunch: _____ ☐ Dinner: _____ ☐ Snacks: _____

What does your child usually have for a snack? _____

_____

Does your child eat out (i.e. fast-foods, restaurants, take-out, etc.)? ☐ Yes or ☐ No

How often and where? _____

_____

Does your child take lunch to school or buy lunch at school? _____

Examples of food choices: _____

_____

What does your child not like to eat? _____

What foods do they like the most? _____

Which of the following problems (if any) does your child experience?

☐ Bloating ☐ Blood in Stool ☐ Constipation (less than 1 bowel movement per day or sluggishness) ☐ Diarrhea

☐ Gas ☐ Heartburn ☐ Incontinence ☐ Nausea

☐ Rectal Itching or Burning ☐ Stomach Ache ☐ Vomiting

Is your child physically active? ☐ Yes or ☐ No

If yes, how often and what type of activity? _____

_____

What, if any, other concerns you did not describe before do you have about your child's appetite, feeding behavior, or diet? _____

_____

_____

Bariatric Surgery

Is your child considering bariatric surgery? ☐ Yes or ☐ No or ☐ Not Applicable

Which procedure is your child having? _____

What is the surgery date? _____/_____/_____

What is the name of the surgeon? _____

Additional Notes: