Bordeaux Nutrition, LLC ~ Medical Nutrition Therapy (MNT)
Renée J. Bordeaux, RD, CDN, CPT ~ Jacqui J. Campbell, MS, RD, CDN
66 Cedar Street, Suite 305 ~ Newington, CT 06111
Phone: 860-757-3474 ~ Fax: 860-523-0141

PATIENT REGISTRATION INFORMATION

First Name ___________________ Middle Initial _____ Last Name ______________________________________

ADDRESS_____________________________________ City __________________ST______ Zip_________________

E-mail ____BIRTHDATE ____/____/_____ AGE _______ M or F

PHONE (H) ______________________(C)______________________ Marital Status: M S Other ________________

May we text you? Y or N (Please note that text messaging is not a secure form of communication) Initial: _____

EMERGENCY CONTACT NAME, RELATION, PHONE:____

PRIMARY DOCTOR ________________________________ PCP Phone/Address ________________________________

SPECIALISTS/THERAPISTS/PSYCHIATRIST (Name, Phone/Address if known)

____

How were you referred? Doctor Ad Friend/Family Internet Insurance Other ___________________________________

PATIENT EMPLOYER _______________________________ OCCUPATION ___________________________________

STUDENT? FT or PT Name of school: ____

PRIMARY INSURANCE

Policy Holder's NAME: _____________________________Policy Holder's Address: ___________________________

City_____________ State______ Zip code: ________Telephone: ( )_____________ Holder's DOB: _________ M or F ?

Ins. Co. and ID #: ____Group No:__________________________

Policy Holder's Employer: ___________________________________ Patient relationship to insured: Self Spouse Child Other

SECONDARY INSURANCE

Policy Holder's NAME _______________________________Policy Holder Birth date _______________________________

City______________ State_______ Zip code: ___________ Telephone: ( )______________ Holder's DOB: _________

Ins. Co. and ID #:____Group No:______________________

Policy Holder's Employer: ___________________________________ Patient relationship to insured: Self Spouse Child Other

You authorize Bordeaux Nutrition, LLC to treat you and bill for your medical nutrition therapy visits. We have a 24 hour cancellation policy. Please call if needing to cancel. You may be responsible for the full appointment fee. Insurance will not cover for missed appointments. Thank you.

SIGNATURE____ **DATE**______________________________

Parent/Guardian____ **DATE**______________________________

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RESPONSIBILITY FOR PAYMENT

I, ________________________________, understand that Bordeaux Nutrition, LLC, may bill me for services rendered if my insurance company fails to assign payment to Bordeaux Nutrition, LLC, *despite prior approval of services. I agree to be fully and personally responsible for payment*. Bordeaux Nutrition, LLC, agrees to refund me any duplicate payments.

Signature of patient or authorized representative ____

AGREEMENT TO MAINTAIN SIGNATURE ON FILE FOR COMMUNICATIONS WITH PRIVATE INSURANCE

Signature of patient or authorized representative ____

I HEREBY,

I. AUTHORIZE INSURANCE AND / OR MEDICARE PAYMENTS TO BE SENT TO Bordeaux Nutrition, LLC, Medical Nutrition Therapy (MNT) as APPLICABLE.

II. CERTIFY THAT I AM FINANCIALLY RESPONSIBLE FOR ALL SERVICES RENDERED TO ME AND /OR MEMBERS OF MY FAMILY IF INSURANCE OR MEDICARE FAILS TO ASSIGN PAYMENT OR IS NOT APPLICABLE. I CERTIFY THAT PAYMENT WILL BE MADE WITHIN 30 DAYS.

III. CERTIFY THAT I AM RESPONSIBLE FOR COPAYMENTS DUE AT THE TIME OF SERVICE. IF I AM NOT ABLE TO PAY COPAYMENT AT THE TIME OF SERVICE, I WILL ARRANGE PAYMENT OF THE COPAYMENT WITHIN A WEEK FROM THE VISIT. **A FEE OF $150 WILL BE CHARGED FOR AN INITIAL APPOINTMENTS NOT CANCELLED WITHIN 24 HOURS OF VISIT, UNLESS IN CASE OF EMERGENCY. A FEE OF $50 WILL BE CHARGED FOR FOLLOW UPS NOT CANCELLED WITHIN 24 HOURS.**

SIGNATURE ____DATE__________________________________

Parent/Guardian ____DATE__________________________________

PATIENT NAME:____DOB:___________________

FOR RD USE ONLY
IBW:_______________ % IBW_________ ABW: _______________BMI: ___________
KCAL NEEDS: _________________________________ / ____________ kcals / kg

PLEASE COMPLETE THE FOLLOWING QUESTIONS:

WHAT ARE YOUR PERSONAL NUTRITION GOALS? ______________________________________

____

Have you ever worked with a RD? __________ If yes, who: ______________________________

HEALTH STATISTICS

HEIGHT _______ WEIGHT _______ USUAL WEIGHT _______ LAST DATE AT UW___________
PATIENT'S GOAL WEIGHT _______ HIGHEST WEIGHT __________LOWEST________________

ANY SIGNIFICANT WEIGHT CHANGES OVER THE PAST 6 MONTHS? ________________________

PARTICULAR ETHNIC/RELIGIOUS DIETARY PRACTICES?_______________________________________

LIST ANY FOOD ALLERGIES / INTOLERANCES ____

MEDICAL HISTORY INCLUDING ILLNESS, DIAGNOSES, and SURGERIES:

____

____

____

____

BRIEF HISTORY OF EATING D/O BEHAVIOR if applicable. (When it started, behaviors, triggers, etc.)

____

____

____

MEDICATIONS____

____

VITAMIN/MINERAL SUPPLEMENTS ____

____

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PATIENT NAME:____DOB:___________________

PLEASE INDICATE IF YOU OR ANYONE IN YOUR FAMILY HAVE HAD ANY OF THE FOLLOWING SYMPTOMS/CONDITIONS:

Cardiovascular	**Self**	**Family**
High blood pressure	_____	_____
High cholesterol	_____	_____
Heart attack or stroke	_____	_____
Arrhythmia	_____	_____
Muscular, Skeletal, Joints		
Back pain	_____	_____
Joint Pain, stiffness, swelling	_____	_____
Frequent muscle cramps	_____	_____
Arthritis, Rheumatoid or Osteo	_____	_____
Osteoporosis/Osteopenia	_____	_____
Gout	_____	_____
Restless leg syndrome	_____	_____
Digestive/Gastrointestinal		
Low appetite	_____	_____
Constant hunger	_____	_____
Constipation	_____	_____
Diarrhea	_____	_____
Frequent gas, bloating or cramping	_____	_____
Acid reflux/heart burn/indigestion	_____	_____
Frequent nausea	_____	_____
Hiatal hernia	_____	_____
Celiac disease	_____	_____
IBD, Crohns or Ulcerative Colitis	_____	_____
Irritable Bowel Syndrome IBS	_____	_____
Endocrine		
Diabetes Mellitus Type 1	_____	_____
Diabetes Mellitus Type 2	_____	_____
Metabolic Syndrome	_____	_____
Hyperglycemia	_____	_____
Hypoglycemia	_____	_____
Thyroid disorder	_____	_____
Adrenal disorder	_____	_____
Genital/Urinary		
Frequent yeast infections	_____	_____
Urinary tract infections	_____	_____
Urinary incontinence	_____	_____
Kidney disease	_____	_____
Women's Health		
Painful periods	_____	_____
Irregular/ absent periods	_____	_____
Heavy periods/ excessive bleeding	_____	_____
Premenstrual syndrome (PMS)	_____	_____
Endometriosis	_____	_____
Alopecia (female hair loss)	_____	_____
Female hair growth on face/ chest	_____	_____
Liver		
Hepatitis	_____	_____
Cirrhosis	_____	_____

Neurological/ Mental Status	**Self**	**Family**
Anxiety or Depression	_____	_____
Headaches/ Migraines	_____	_____
Mood swings/irritability	_____	_____
Fibromyalgia	_____	_____
Multiple Sclerosis (MS)	_____	_____
ADD/ADHD	_____	_____
Epilepsy or seizures	_____	_____
Energy		
Fatigue, weakness	_____	_____
Lethargy	_____	_____
Hyperactivity	_____	_____
Restlessness	_____	_____
Insomnia	_____	_____
Respiratory/ ENT		
Sinusitis	_____	_____
Ear infections/tubes in ears	_____	_____
Itchy Ears	_____	_____
COPD	_____	_____
Chronic bronchitis	_____	_____
Gagging/throat clearing	_____	_____
Post nasal drip	_____	_____
Asthma	_____	_____
Emphysema	_____	_____
Frequent colds, infections	_____	_____
Chronic cough	_____	_____
Chronic congestion	_____	_____
Skin Disorders		
Eczema	_____	_____
Dermatitis	_____	_____
Psoriasis	_____	_____
Acne	_____	_____
Other skin rashes	_____	_____
Food		
Inability to lose weight	_____	_____
Cravings for sweets, breads, alcohol	_____	_____
Binge eating	_____	_____
Restrictive eating	_____	_____
Allergies/Sensitivities		
Food allergies or sensitivities	_____	_____
Seasonal or environmental allergies	_____	_____
Chemical sensitivity	_____	_____
Other		
Anemia/ blood condition	_____	_____
Vitamin deficiency	_____	_____
Alcohol or substance abuse	_____	_____
Dizziness, low blood pressure	_____	_____
Cancer, type:___________	_____	_____

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PATIENT NAME:____**DOB:**____________________

WHAT ARE YOUR FAVORITE FOODS? ____

WHAT FOODS DO YOU DISLIKE?____

WHO DOES THE COOKING? __________ SHOPPING? ___________ WHERE? ______________________

HOW MANY TIMES A WEEK DO YOU DINE OUT? (Including breakfast, lunch, dinner, beverages, etc.)
WHERE?

____

____

DO YOU DRINK ALCOHOL? _________IF YES, WHAT KIND, HOW OFTEN AND HOW MUCH AT THAT TIME?

____

DO YOU SMOKE? _________IF PREVIOUS SMOKER, WHEN DID YOU QUIT?_____________________

DO YOU EXERCISE? IF SO WHAT, HOW LONG AND HOW OFTEN? ______________________________

____

USUAL DIETARY PATTERN (As best as you can)

Please be as specific as possible. Include all beverages, condiments, and portion sizes.

Time	**Food Item and Method of Preparation**	**Amount Eaten**	**Where**

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Our HIPAA Policies and Practices

Keeping our client's personal health information secure is a top priority for us at Bordeaux Nutrition, LLC. While information is the cornerstone of our ability to provide superior MNT services, our most important asset is our client's trust. This notice tells you how we collect, handle, and disclose personal health information about you. **If you want to limit our disclosure of this information, please submit your wishes to us in writing (see below).**

We protect personal health information we collect about you by maintaining physical, electronic, and procedural safeguards that meet or exceed applicable law.

Protected Health Information (PHI)

We Collect and May Disclose

The protected health information we collect about you comes from the following sources:

- Information received from your physician or other healthcare provider.
- Information we receive from you while providing MNT services and on enrollment forms, assessment surveys, or other forms.
- Information we receive from other sources such as caregiver, insurer, employer and other third parties.

Protected health information will not be used for marketing, except if the communication is by a Bordeaux Nutrition, LLC, staff member directly to you or to provide you with education or promotional material from us. PHI also includes when Bordeaux Nutrition, LLC, Medical Nutrition Therapy (MNT) is required to disclose information without your consent such as emergencies, by order of court, criminal activity, etc.

We may disclose any of your protected health information to the following entities as long as this information is directly related to health services or your individual care. These entities include doctors, hospitals, health care providers, pharmacies, insurance companies, family members or other persons involved directly in your individual care.

We will obtain your written authorization before using or disclosing your protected health information for purposes other than the reasons listed above (or as otherwise permitted or required by law). You may amend and/or revoke this authorization in writing at any time stating specific exclusions or restrictions. Upon receipt of the written revocation, we will stop using or disclosing your information, except to the extent that we have already taken action in reliance on the authorization.

I, ______________________, authorize Bordeaux Nutrition LLC to text me regarding my care, knowing that communication via text may not be secure. Initial:______

SIGNATURE ____DATE________________________________

Parent/Guardian ____DATE________________________________

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CONSENT FOR THE RELEASE OF MEDICAL INFORMATION

I, (print name)____________________ do hereby authorize Bordeaux Nutrition, LLC to obtain and/or release any information related to the development, implementation, and evaluation of my individual treatment plan, and to the payment of claims for services to Bordeaux Nutrition, LLC. I authorize Bordeaux Nutrition, LLC to obtain my protected health information from the following providers.

PROVIDER NAME/CREDENTIALS	PHONE	FAX
PRIMARY CARE PHYSICIAN		
THERAPIST		
PSYCHIATRIST		
SPECIALIST/OTHER (OBGYN, GI, ENDO, etc)		
SPECIALIST/OTHER (OBGYN, GI, ENDO, etc)		

This information is for use by the recipient named above only. Under the *Family Education and Privacy Act of 1974,* this information cannot be given to any other individual or agency without the patient's consent:

SIGNATURE ____DATE_________________________________

Parent/Guardian ____DATE_________________________________

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~ PLEASE MAINTAIN THIS COPY FOR YOUR RECORDS ~

PRACTICE POLICIES

In order to meet your needs and provide you the best possible care, please honor the following guidelines:

1. Please be aware that initial appointments typically last from 2-2.5 hours. Follow up visits last ~ 1 hour. We typically schedule clients one right after the other. If you are more than 15 minutes late, we may need to reschedule you and you will be charged for the missed visit. Please call ahead if you may be a few minutes late. Thank you.

2. Please have your current insurance card(s) and picture ID (driver's license) available on your first visit and to make available any new cards as you may receive them.

3. You must pay your co-pay, coinsurance or cost of visit when services are rendered. Payment options are cash, check, debit and credit (VISA, MC, Discover).

4. All outstanding balances will be billed to you. Late fees will be incurred after 30 days. Your account will be sent to collection if not received in 45 days and will include any collection and late fees you have incurred. Please note you are responsible for payment if insurance denies payment, regardless of quoted benefits.

5. You must complete and sign a Patient Registration Form with accurate information including that of your spouse or parent if they are the policy holder. Please complete the registration documents prior to your first visit.

6. Please record the date and time of your appointment. **You will be charged $150 if you miss your initial appointment and $50 for your follow up appointment if you do not cancel within 24 hours**. Extenuating circumstances and inclement weather will be considered. Please call to discuss your needs.

7. Bring copies of your most recent lab values or ask your doctor to fax them to us prior to your first visit, if available (preferred but not required). Fax: 860-523-0141