ROBYN A. COTLER, MS,RD,CDN
700 OLD COUNTRY ROAD
SUITE 204
PLAINVIEW, NEW YORK 11803
516.433.9496
COTLERNUTRITION@GMAIL.COM

NAME: _____
(LAST) (FIRST)
ADDRESS: _____
(#STREET NAME) (CITY) (ZIP CODE)
EMAIL ADDRESS:
_____

HOME PHONE:_____ CELL PHONE:_____

SOCIAL SECURITY NUMBER:_____
DATE OF BIRTH:_____

REFERRING DOCTOR/ADDRESS/PHONE#:

NAME OF **PRIMARY INSURANCE** COMPANY:

PRIMARY INSURANCE ADDRESS:
_____
(STREET #) (STREET NAME) (CITY) (STATE) (ZIP CODE)

PRIMARY INSURANCE ID#: _____
SECONDARY INSURANCE: _____ ADDRESS:
_____ ID#:
_____

PRIVACY CONSENT, AUTHORIZATION FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS:

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I PERMIT A COPY OF THIS AUTHOIZATION TO BE USED IN PLACE OF THE ORIGINAL. I AGREE TO PAY **ROBYN A. COTLER, MS,RD,CDN** IN A TIMELY AND CURRENT MANNER ANY BALANCE OF MEDICAL CHARGES AND EXPENSES SUCH AS SERVICES NOT COVERED BY INSURANCE PLAN, COPAYS AND/OR DEDUCTIBLES THAT ARE THE PATIENT'S RESPONSIBILITY – YOU MUST PRESENT THE REFERRAL FORM AT THE TIME OF VISIT. **ONLY CASH /Venmo OR CHECKS ACCEPTED**

SIGNATURE: _____ DATE: _____

MEDICAL HISTORY:

SURGERIES (PLEASE LIST DATES):

_____

HT: _____ CBW: _____ BMI: ____ WEIGHT HISTORY: _____

FOOD ALLERGIES: _____

RECENT LAB DATA: CHOLESTEROL: LDL: HDL: TG: HGA1C:

FASTING BLOOD SUGAR: BP: CRP: SLEEP: OTHER

MEDICAL_____

_____

CURRENT MEDICATIONS:

MED NAME: DOSE: REASON FOR MED:

1-

2-

3-

4-

5-

6-

VITAMIN/MINERAL SUPPLEMENTS (LIST DOSE):

NAME: DOSE: REASON FOR SUPPLEMENT

1-

2-

3-

4-

5-

DO YOU SMOKE? IF YES, HOW MUCH? _____

WEEKLY ALCOHOL INTAKE:

_____ REASON FOR VISIT:

_____

_____

REFERRING DOCTOR: _____

REFERRING DOCTOR PHONE & ADDRESS: (_____)_____

DIRECTIONS: LIE TO EXIT 44 S. TAKE TO OLD COUNTRY ROAD EXIT. MAKE RIGHT ONTO OLD COUNTRY ROAD. DRIVE APPROXIMATELY ½ MILE. BUILDING WILL BE ON RIGHT. **CHECK IN WITH THE RECEPTIONIST!!!**

COTLER NUTRITION CONSULTING SERVICES
ROBYN A. COTLER, MS,RD,CDN
700 OLD COUNTRY ROAD
PLAINVIEW, NY 11803
516-433-9496

CREDIT CARD INFORMATION :

NAME ON CARD:_____ TYPE OF CC:_____

CC #: _____ EXP:_____CID:_____

SIGNATURE:

_____

No Show/Cancellation Policy

Once an appointment is scheduled, you are expected to pay out of pocket for the full fee, equivalent to that reimbursed for attended appointments, unless you provide 36 hours advanced notice of cancellation.

Leave notice of cancellations on my voice mail at: 516.433.9496

OR

EMAIL: COTLERNUTRITION@GMAIL.COM

Patient Signature: _____ **Date:** _____

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*Current Fees: January 2023

Initial Nutrition Visit (50 minutes)- $250.00 -check/cash/venmo)

Initial Nutrition F/U (40 minutes)- $220.00 check/cash/venmo)

Secondary Follow up Visit (30 minutes)- $180.00 check/cash/venmo)

Weekly visits (30 minutes)- $120 (check/cash/venmo)

*Fees are pending on Health Insurance Policy. Should health insurance policy cover medical nutrition therapy above fees are null and void.