

ROBYN A. COTLER, MS,RD,CDN
700 OLD COUNTRY ROAD
SUITE 204
PLAINVIEW, NEW YORK 11803
516.551-5701
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 AUTHORIZATION 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-

History of Smoking: Did you ever SMOKE? _____ YES _____ NO
DO YOU SMOKE? IF YES, HOW MUCH? _____

WEEKLY ALCOHOL INTAKE: # of

drinks/week: _____

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
516-551-5701

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:

516.551.5701

or

EMAIL: COTLERNUTRITION@GMAIL.COM

Patient Signature: _____ **Date:** _____

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*Current Fees: January 2025

Initial Nutrition Visit (50 minutes)- \$250.00 -check/cash/Zelle/Venmo)

Initial Nutrition F/U (40 minutes)- \$220.00 check/cash/Zelle/Venmo)

Secondary Follow up Visit (30 minutes)- \$180.00 check/cash/Zelle/Venmo)

Weekly visits (30 minutes)- \$150.00 (check/cash/Zelle/Venmo)

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