Ann Silver Nutrition, LLC
PO Box 399
Sag Harbor, New York 11963
631.324.1953
www.annsilverrd.com
annsilverrd@gmail.com

Patient Registration

DATE: _____

PATIENT'S NAME:	DATE OF BIRTH:	AGE:	SEX:
MAILING ADDRESS:			
TOWN: _____	STATE: _____	ZIP CODE: _____	
PREFERRED PHONE #: _____	ALTERNATE PHONE #: _____		
E-MAIL: _____ →WANT TO RECEIVE Ann's newsletter? ☐Yes ☐No			
EMPLOYMENT STATUS: ☐Full time ☐Part time ☐Unemployed ☐Student	PATIENT'S OCCUPATION:		
EDUCATION LEVEL (highest level): Grade level: College ☐ Graduate school ☐	EMPLOYER:		
PATIENT SOCIAL SECURITY#:			
Marital status of patient: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed			
If patient is under 18 years or a dependent please complete: PARENT/GUARDIAN NAME: _____ PARENT/GUARDIAN DATE OF BIRTH: _____			
PARENT/GUARDIAN SOCIAL SECURITY#:			
Marital status of parents: ☐Single ☐Married ☐Divorced ☐Separated ☐Widowed			

Provide a copy of the front and back of all insurance cards

PRIMARY INSURANCE COMPANY: Click or tap here to enter text.
INSURANCE ID #: _____ COPAY $: _____
PRIMARY INSURED'S NAME: _____ PRIMARY INSURED'S BIRTHDATE: _____ (Insured's name is not necessarily the patient's name, but the family member who has the insurance)
SECONDARY INSURANCE COMPANY:
SECONDARY INSURANCE ID #: _____ SECONDARY COPAY $: _____
SECONDARY INSURED'S NAME: _____ SECONDARY INSURED'S BIRTHDATE: _____ (Insured's name is not necessarily the patient's name, but the family member who has the insurance

PRIMARY or REFERRING PHYSICIAN'S NAME: _____ PHYSICIAN'S PHONE #: _____
PHYSICIAN'S ADDRESS:
WHO REFERRED YOU?

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Office Policies

1. Payment for services, including copays, is due at the time services are rendered.
2. Assignment is accepted only from those insurance companies for which we are a provider.
3. You are responsible for keeping your insurance information updated. Obtain a referral if your insurance policy requires one (Medicare requires it). You will not be seen if you do not have a referral. If you want to be seen without a referral, then you agree to self-pay for the appointment at $300.00 for an initial appointment and $180.00 for follow-up appointments.
4. Contact your insurance to verify your coverage for nutrition therapy. The codes, if asked, are 97802 and 97803.
5. If your insurance denies coverage or payment, you are financially responsible for the full cost of the visit.
6. If we are not a provider of your insurance upon payment for the appointment, you will be provided a Superbill for you to submit to your insurance for you to be reimbursed.
7. Payment can be made via cash, checks, debit card, Master Card, Visa, and American Express.
8. There is a $50.00 fee for any returned/bounced checks.
9. *Twenty-four (24) hour advance notice is required for cancellations or change of appointments to avoid a $180.00 fee.*
10. **We require a credit card on file** prior to your appointment to ensure we are paid for visits not cancelled within 24 hours, unforeseen copays or denied insurance claims. This information will not be shared with anyone. You will be informed if a charge is made to your credit card.

Name on Credit card:			
Credit card #	Exp date:	CVV:	Billing zip code:

11. You will not be seen if you have an outstanding balance.
12. Outstanding balances not paid 30 days from final invoice will incur a 40% non-payment fee to the balance. Your account will be sent for collection.

By signing below I have read, understood, and agreed to these office policies.

Signature: _____ Relationship to patient: _____

Print Name: _____Date: _____

Receipt of Privacy Practice Notice

Please read the copy of Ann Silver's Notice of Privacy Practice (on the next page).
Your signature with date acknowledges you have received and read Ann Silver's Notice of Privacy Practices.

Person completing this form:
Signature: _____ Relationship to patient: _____

Print Name: _____Date: _____

Permission to Release Health Information

I grant the right to Ann M. Silver, MS, RDN, CDE, CDN to release and/or obtain health information about _____ (patient's name) to my insurance for payment and my health care provider.

Name of health care provider: _____
☐ Please fax my provider I am under Ann Silver's care: Name_____ Fax #:_____
Person completing this form:
Signature: _____ Relationship to patient: _____

Print Name: _____ Date: _____

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Notice of Privacy Practices
Effective Date: April 14, 2003

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
If you have any questions about this notice, please contact:
Ann M. Silver, MS, RDN, CDE, CDN
Nutritionist
PO Box 399, Sag Harbor, NY 11963
(631) 324-1953 office
annsilverrd@gmail.com (email)

OUR LEGAL DUTY:
We are required by applicable federal and state law to maintain the privacy of your health information. We reserve the right to change our privacy. Before we make a significant change in our privacy practices, we will change this Notice and make the new Notice available. You may request a copy of our Notice at any time. For more information about our privacy practices or for additional copies of this Notice, please contact us using the information at the top of this page.

USE AND DISCLOSURE OF HEALTH INFORMATION
Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.
Payment for Services: We may use or disclose your health information to obtain payment for services we provide to you.
Healthcare Operations: We may use or disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, case management, review the competence or qualification of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing and other activities.
Required By Law: We will disclose your health information about you when required to do so by federal, state or local law.
Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe you are a victim of abuse, neglect or domestic violence or the possible victim of other crimes. We may disclose this type of information to the extent necessary to avert a serious threat to your health or safety or the health or safety of others.
Business Associate: We may disclose information to business associates who perform services on our behalf (such as billing companies;) however, we require them to appropriately safeguard your information.
Appointment Reminders: We may use or disclose your health information to contact you as a reminder (such as voicemail messages, email, postcards, or letters) that you have an appointment for treatment or medical care with Ann Silver, Nutritionist.

PATIENT/CLIENT RIGHTS
Access: You have the right to inspect and copy your health information, with limited exceptions. Submit your request in writing to Ann Silver, Nutritionist. A fee will be charged for the costs associated with your request. There are certain situations in which we are not required to comply with your request. In these circumstances, we will respond to you in writing, stating why we will not grant your request and describe any rights you may have to request a review of our denial.
Disclosures Accounting: You have the right to receive a list of instances in which we or our business associates disclosed your health information for purposes, other than treatment, payment, healthcare operations and certain activities, for the last 6 years, but not before April 14, 2003. If you request an accounting more than once in a 12-month period, you will be charged a reasonable cost-based fee for responding to these requests.
Amendment: You have the right to request that we amend your health information. (Your request must be in writing, and it must explain why the information should be amended.) We may deny your request under certain circumstances.
Restrictions: You have the right to request we place additional restrictions on our use of your health information. We are not required to agree to additional restrictions, but if we do, we will abide by our agreement (except in an emergency).
Alternative Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. To request alternative communications, you must make your request in writing. We will accommodate all reasonable requests.
Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice at any time by contacting Ann Silver.

QUESTIONS AND COMPLAINTS
If you want more information about our privacy practices or have questions or concerns, please contact us.
If you are concerned that we may have violated your privacy rights or you disagree with a decision we made about access to your health information or in response to a request you made to amend or restrict the use of disclosure of your health information or to have us communicate with you by alternative means or at alternative locations, you may record your complaint to us by using the contact information at the beginning of this Notice. You also may submit a written complaint to the Secretary of the Department of Health and Human Services. We support your right to the privacy of your health information. If you file a complaint, we will not take any action against you or change our treatment of you in any way. We support your right to the privacy of your health information.

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Patient Information

PATIENT NAME: _____ DATE: _____

Explain the reason for this visit and what you ultimately wish to accomplish:

Medical Conditions/History

Disease/Condition	Self	Family (identify relation)	Disease/Condition	Self	Family (identify relation)
Asthma	____	_____	Kidney Disease	____	_____
Cancer, type: _____	____	_____	Headaches	____	_____
Cardiovascular Disease	____	_____	Heart Attack	____	_____
Constipation	____	_____	High Cholesterol	____	_____
Diabetes	____	_____	Hypertension	____	_____
Diarrhea	____	_____	Intestinal Problems	____	_____
Drug Dependency	____	_____	Menstrual Problems	____	_____
Eating Disorder	____	_____	Mental Health Issues	____	_____
Food Allergies	____	_____	Obesity	____	_____
Food Intolerances	____	_____	Osteoporosis	____	_____
Other, specify:	____	_____			

List all your current medical conditions:
_____

Medications, Supplements, Vitamins, Over the Counter Medications (list below or attach a list with the following information

Name of medication	Dose	Tablet, Capsule or injection	When you take	Why you take it

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PATIENT NAME: _____ DATE: _____

Weight Information

Height: ___ feet __ inches	Current weight: ____ lb	Desired weight: ____ lb	Usual weight: ____ lb
Are you concerned about your weight? ☐No ☐Yes, explain: _____			
Have you tried to lose weight before? ☐No ☐Yes, explain below:			

When?	What approach?	# pounds lost?	How long weight loss lasted?	Why you stopped?

Family Weight/Eating Information

Explain about members in your family whom are overweight:
Explain about members in your family whom are underweight:
Explain about members in your family on a diet:
Does your family eat together? ☐No ☐Yes If yes, when?
Describe family meals:

Eating Habits	No	Yes, please explain:
Do you experience times during which you eat uncontrollably?		
Do you induce yourself to vomit or have you in the past?		
Do you use or have used laxatives?		
Do you hurt or harm yourself?		
Do you have or had negative emotions or feelings?		
Have you ever been diagnosed with an eating disorder?		
Are you currently or have you received treatment for an eating disorder?		

	No	Yes	
Do you skip meals?	☐	☐	If yes, why?
Do you eat out?	☐	☐	Which meals? _____ How often do you eat out? _____ What restaurants do you usually choose? _____
Do you know how to cook?	☐	☐	Who usually prepares food at home? _____ Who does the grocery shopping at home? _____
Do you have enough money for food?	☐	☐	
Do you snack?	☐	☐	If yes, when? _____ What do you typically have for a snack? _____

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PATIENT NAME: _____ DATE: _____

Eating Behaviors

	No	Yes		No	Yes
Do you eat standing up?			Do you eat fast?		
Do you eat in the car?			Do you eat when bored?		
Do you eat while watching TV?			Do you eat when stressed?		
Do you eat while reading or on the computer?			Do you eat when you are anxious?		
Do your prefer eating alone?			Do you eat when you are lonely?		
Do you eat with others?			Do you eat when you are not hungry?		
Do you read Nutrition Facts labels?	☐	☐	If yes, what do you look at on the label? _____		
What are your favorite foods?					
What foods do you avoid and why?					

	No	Yes	
Have you been advised by your physician to follow a specific diet?	☐	☐	If yes, what is the diet?
Are you currently following that diet?	☐	☐	If not, why? _____ If yes, what changes have you made? _____

Physical activity

Do you participate in physical activity? ☐Yes ☐No If no, explain? _____

If yes, describe below:

Activity	How many minutes/session?	How many times/week?

	No	Yes	
Do you drink alcohol?			# drinks/per week:
Do you smoke cigarettes?			# cigarettes/day: ___ How long have you smoked? _____
Do you use smoke marijuana?			If yes, explain:
Do you use/have used illegal drugs?			

This is important…

Please keep a 3-day food journal for your appointment. This will provide us an idea of your eating.
Indicate the time of day you ate and/or drank, specify the food and/or beverage and the quantity. The more specific the information the more helpful, for example instead of a bowl of cereal write1 cup cooked oatmeal. A journal is available at annsilverrd.com/forms.html