Nutrition Energy
Lauren Antonucci, MS, RD, CSSD, CDE, CDN
57 West 57th Street, Suite 1211
New York, NY 10019

Dx: _____

New Patient Registration & Personal Information

Last Name/First Name: _____

Address: _____ Apt.: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Work: _____ Cell: _____

E-mail: _____ Referring Physician: _____

Primary Care Physician: _____ Phone Number: _____

May we contact your primary or referring physician regarding your appointment? _____

Social Security: _____ Marital Status: _____ Married _____ Single

Sex: ____ Male ____ Female Date of Birth: _____ Referred By: _____

Employer: _____

Phone number: _____ Address: _____

In case of emergency contact: _____ Phone#: _____

Insurance Information:

Relationship to Insured: _____ Self _____ Spouse _____ Child/Financial Dependent

Name of Insured: _____ ID#: _____

Insurance Carrier: _____ Phone# _____

Credit Card on File:

Although collection of all copay, self-pay and out-of-network deductible amounts is expected at time of service, we require a credit card on file in order to expedite your billing for payment of all additional fees, including in-network deductibles, late cancel charges and co-insurances. Your card will be billed as applicable and you will receive a paid statement and your credit card receipts.

Card Type: Visa MasterCard AMEX

Card#: _____ Exp.: _____

Patient Signature: _____ **Date:** _____

Privacy Notice

THE FOLLOWING NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. **PLEASE REVIEW IT CAREFULLY AND SIGN BELOW.**

Effective April 8, 2014

I acknowledge I have read and understand this privacy notice. I understand this privacy notice is available in copy form at my request and is also available on Nutrition Energy's website (nutritionenergy.com).

_____ _____ _____

Signature Print Name Date

I give permission to Nutrition Energy to speak with my primary care physician _____ regarding my health laboratory values and care.

Additionally, I make the following special request for confidential communications:

_____

_____

_____

_____ _____

Signature Date

Nutrition Energy
Lauren Antonucci, MS, RD, CSSD, CDE, CDN
57 West 57th Street, Suite 1211
New York, NY 10019

Private Payment Agreement

Date: _____

Dear _____

Please take a moment to review the private, out-of-pocket, payment information. We are happy to assist you in submitting to an out-of-network provider by providing an itemized receipt for services rendered. In addition, in the event your insurance claim is denied, you will be responsible for the following out-of-pocket expenses:

_____$245___Initial evaluation

_____$210____Follow-up visits (45-60 minutes)

_____$125____Follow-up visits (30 minutes)

_____$79_____Resting Metabolic Rate Test, when added to an appointment

All payments are due at time of service. Missed appointments and appointments not canceled **by either phone call or voicemail message** to the front desk within 24 hours of each scheduled appointment are subject to a **$150** charge for the evaluation, **$100** for 60 minute f/u appointments and **$75** for 30 minute f/u appointments that is not billable to any insurance. There are **no exceptions** to this policy.

If you have any questions or concerns, please do not hesitate to contact Nutrition Energy at (646) 361-6803.

Thank you for your attention to this matter.

I have read and understood this agreement.

Patient Signature: _____ **Date:** _____

nutrition energy

DATE: _____

Director, Lauren Antonucci, MS, RD, CSSD, CDE, CDN
57 West 57th Street, Suite 1211 New York, NY
www.nutritionenergy.com – (646) 361-6803

Nutrition Screening Form

PLEASE INDICATE (☑) IF ANY OF THE FOLLOWING CONDITIONS APPLY:

Condition	You	Family History?
693.1 Allergy		
626.0 Amenorrhea		
280.9 Anemia (Iron deficiency)		
307.1 Anorexia Nervosa		
716.90 Arthritis		
493.90 Asthma		
307.51 Bulimia Nervosa		
Cancer (specify type below)		
579.0 Celiac Disease		
556.9 Colitis (Ulcerative)		
564.00 Constipation		
555.1 Crohn's Disease		
276.51 Dehydration		
564.5 Diarrhea		
562.11 Diverticulitis		
250.03 DIABETES Type 1		
250.02 DIABETES Type 2		
530.81 Esophageal Reflux		
783.4 Failure to Thrive-child		
780.79 Fatigue		
V17.49 HEART DISEASE		

Condition	You	Family History?
245.2 Hashimotos		
272.0 High Cholesterol		
401.9 HYPERTENSION		
Hypertension Complicating Pregnancy		
790.29 Hyperglycemia		
242.90 Hyperthyroidism		
251.2 Hypoglycemia		
244.9 Hypothyroidism		
564.1 Irritable Bowel Syndrome		
277.7 Insulin Resistance		
271.3 Lactose Intolerance		
787.0 Nausea and Vomiting		
733.90 Osteopenia		
733.0 Osteoporosis		
256.4 PCOS		
790.29 Pre-diabetes		
585 Renal Disease		
268.9 Vitamin D Deficiency		
281.1 Vitamin B12 deficiency		

Other relevant conditions (please indicate below):

Name _____ Signature _____

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Nutrition Counseling Patient Agreement

Thank you for choosing Nutrition Energy for your dietary needs. Please read and sign the following agreement; it lays out our billing, scheduling and cancellation procedures. If you have any questions, please ask for clarification.

- Payment of all fees is expected at time of service or via credit card on file. Will assist you in submitting claims to your insurance carrier. However, you are still responsible for any deductible, co-insurance/co-payment or any claims denied by your insurance carrier.

- I hereby authorize payment of medical benefits directly to Lauren Antonucci and Nutrition Energy for all services rendered where applicable.

- I hereby authorize Nutrition Energy, having treated me, to release to government agencies, insurance carriers and all others who are financially liable for my care, all information to substantiate payments for my care and to permit representatives thereof to examine and make copies of all records related to such care and treatment. *I understand that if at any point my insurance coverage changes, I am to notify administrative staff prior to my next visit.* Failure to do so will result in me being responsible for the full amount of all services.

- I understand that in the event my insurance requires a referral from my primary care physician, and I did not obtain one, I may be responsible for the full amount of the appointment should the claim deny.

- Nutrition Energy does not make follow-up appointment reminder calls. You are responsible for knowing when your next appointment is scheduled. Feel free to call the office to confirm dates and/or times of your next appointment. Failure to remember your appointment may result in a Late Cancel or No Show Fee.

- A scheduled appointment must ***be cancelled at least 24 hours in advance by phone or voicemail message or a Late Cancel Fee will be assessed ($ 150 for the evaluation, $75 for 30 minute appointments and $100 for 60 minute appointments)*** Similarly, if you do not show up for a scheduled appointment the fee will be assessed. This fee is due at the time of your scheduled appointment, will be charged to the credit card you provided on file (either given by phone or via registration form), and is not billable to any insurance carrier.

- If I default on my account, I understand I will be subject to finance and/or legal fees in addition to the total account balance.

I have read and understood this agreement.

Patient Signature:_____ **Date:** _____