Elizabeth Baron Cole and Associates

REGISTERED DIETITIAN NUTRITIONISTS • MEDICAL NUTRITION THERAPISTS • CERTIFIED HEALTH & FITNESS SPECIALIST & TRAINERS
DISEASE PREVENTION MEDICAL PROFESSIONALS • NUTRITION, EXERCISE, LIFESTYLE COUNSELORS

Elizabeth Baron Cole, BS, RDN, MNT, CHFS
Evette Richardson, MS, RDN, MNT, CPT
Lori Salerno, MS, RDN, MNT, CPT
www.eatwelldailynutrition.com

2121 Wilshire Blvd., Suite 302
Santa Monica, CA 90403
T 310.453.5212 F 310.829.0891
eatwelldaily@gmail.com

PATIENT INFORMATION

PATIENT NAME _____ ☐Mr. ☐Mrs. ☐Dr. ☐Ms. ☐Miss

Home Phone _____ Mobile Phone _____

Work Phone _____ Email _____

Address _____

Birthdate _____ Driver's License Number _____

Occupation _____

- As a courtesy, we contact you to confirm your established appointments. Please place an **asterisk (*)** next to the phone number or email at which you would ***prefer*** to be contacted.
- Please attach your business card when submitting this form (if applicable).

Current Primary Concerns _____

Referral Source _____ Primary Physician _____

Other Healthcare Professionals _____

If you have had nutrition counseling before, with whom and when? _____

Height _____ Weight _____ Desired Weight _____

MEDICATIONS	REASON FOR TAKING	LENGTH OF USE	SUPPLEMENTS	REASON FOR TAKING	LENGTH OF USE
1.			1.		
2.			2.		
3.			3.		
4.			4.		
5.			5.		
6.			6.		
7.			7.		
8.			8.		
9.			9.		
10.			10.		

WELCOME TO OUR PRACTICE

We are delighted to meet you and get you started on your path to greater health and well-being.
We strive to provide the finest professional care and attention you may need throughout our very valuable time together.
We regard our association with you as a confidential relationship and we will personalize your program to assure your greatest success.
As a courtesy to our patients, we offer a brief monthly Nutrition News Note / Blog via e-mail.
Please let us know if you would you like to receive this. ☐ YES ☐ NO

THE FOLLOWING GUIDELINES ASSURE YOUR UNDERSTANDING OF OUR PRACTICE POLICIES

- **LENGTH OF SESSIONS**: Your first session is 1½ hours. Follow-ups are 60, 45 or 30 minutes based on your needs.
- **FREQUENCY OF VISITS**: Your first two appointments are one to two weeks apart. Frequency of follow-up sessions varies based on your needs.
- **SCHEDULING**: At the end of every appointment, we assess and determine an appropriate time for follow-up. You may schedule a series of sessions to secure a favorite time slot that fits you best. Please bring your calendar.
- **EMAIL / PHONE / SKYPE**: We are available to answer questions or offer assistance between office visits. Please call us and arrange an appointment time to communicate in any of these fashions. Same charges and payment by credit card apply at the time of service.
- **CANCELLATIONS**: To avoid full charge of a missed appointment, please provide us with 24 hours' notice so that we may offer your scheduled appointment time to another patient.
- **FEES**: Prior to our first appointment, our office staff has informed you of our fee structure.
- **PAYMENT**: Full payment is due at time of service (regardless of late arrival or early departure) with Visa, MasterCard, check or cash.
- **RETURNED CHECKS**: A fee of $25.00 will be assessed on checks returned for non-sufficient funds. We allow ten business days for payment of appointment and fee to avoid the matter being sent to collections.
- **MEDICARE PATIENTS**: Medicare places severe restrictions on Registered Dietitian Nutritionists regarding how to care for our patients. We prefer to offer personalized, regular counseling as needed to secure your success. We have therefore chosen to "opt out" and are not Medicare providers. In concert with this position, we WILL NOT provide any billing materials pertaining to our counseling sessions to Medicare, secondary insurance companies, or Medicare patients.
- **NON-MEDICARE PATIENTS**: We will assist you in attempting to acquire reimbursement for our services by providing the necessary documents you need to send to your insurance company:
  (1) Referral form completed and signed by your physician, including your diagnosis.
  (2) Billing Statement from our practice pertaining to your counseling appointments.

YOUR SIGNATURE IMPLIES YOU HAVE READ AND AGREE TO THE ABOVE POLICIES OF OUR PRACTICE:

_____ _____
PATIENT DATED

AUTHORIZATION FOR CORRESPONDENCE, DISCLOSURE, USE OF MEDICAL INFORMATION

I authorize Elizabeth Baron Cole and Associates to receive and/or release confidential information and records to, or from, allied healthcare practitioners. A photocopy or facsimile of this authorization shall be considered as effective and valid as the original.

_____ _____ _____
PATIENT REGISTERED DIETITIAN NUTRITIONIST DATED