NEW PATIENT FORM
Kati Joyner MA, RDN, LDN, CEDRD-S

Date: _____/_____/_____

PATIENT INFORMATION:
Patient Name:
_____
_____Address_____
_____
City: _____ State: _____
Zip_____ E-mail:_____
Telephone: (cell/home) _____
(work)_____
Sex:____M____F____Other Identified Gender

Date of Birth: _____/_____/_____ Age_____

Patient relationship to insured?_____(e.g. self, spouse, child, etc)

How did you hear about Kati Joyner?_____

MEDICAL AND NUTRITION HISTORY

Height: _____ Current Weight: _____

Highest Weight_____ Lowest Weight_____

Weight 6 months ago_____ Weight 1 year ago_____

What is the weight you desire to be?_____

Circle the following that you have been diagnosed with:

High Blood Pressure ☐

High Cholesterol ☐

Diabetes: Type 1, Type 2, or Gestational ☐

Cancer type:☐_____

Hypothyroidism ☐

Hyperthyroidism ☐

Polycystic Ovarian Syndrome (PCOS) ☐

Endometriosis ☐

Fibromyalgia ☐

Autoimmune Disorder ☐

*Food Allergies type:*_☐_____

*Digestive Problems type (e.g. constipation, diarrhea, etc):*_____ ☐

Stomach Ulcers ☐

Osteoporosis or Osteopenia ☐

Anemia ☐

Migraines ☐

Sleep Apnea ☐

Back Problems ☐

Anxiety ☐

Depression ☐

OCD ☐

Bipolar ☐

Autism ☐

Eating Disorder type: (ie. Anorexia, Bulimia, BED, ARFID, OSFED)

_____

Any others not listed:

_____

_____

_____

If you have a history of any eating disorder, and have received treatment, please list your treatment history:

_____

_____

_____
_____

If you have a history of an eating disorder how long have you struggled with your eating
disorder?_____
_____

Please list any medications you are currently taking:
_____
_____
_____
_____

Please list any vitamins, herbs, or supplements you are currently taking:
_____
_____

Are there any doctors, healers, or therapies with which you are currently involved? If so please list their names and reasons for seeing
them_____

_____
_____

Do you sleep well?_____ How many hours a night do you sleep?_____

Rate the following on a scale of 1-10 with 1 being low and 10 being high:

Energy level?_____ Stress Level?_____

How do you cope with
stress?_____

Women only: Are your periods regular?_____How many days is your flow?_____

How frequent?_____ Painful or symptomatic?_____

Are you on any form of birth control?_____

Are you currently exercising? ☐ Yes ☐ No

If yes, how often, how long, and what types?

_____
_____
_____

What is your current occupation?

_____

How many hours/week do you work? _____

Do you smoke? ☐ Yes ☐ No Do you drink? ☐ Yes ☐ No

If yes to either, how much and how often?

_____

Have you ever been seen by a dietitian before? ☐ Yes ☐ No

If yes, how long ago? _____

Tell me about your experience (e.g. helpful, not helpful, etc)

_____
_____
_____

What do you hope to accomplish or adjust in our work together?_____

_____
_____
_____
_____

Policies and Payments
Kati Joyner MA, RDN, LDN, CEDRD-S

The following information is provided to avoid any misunderstandings of the policies and payment for professional services provided.

- **Missed Appointments:** I require a 24 hour cancellation policy. If you do not call within 24 hours prior to your appointment, you will be responsible for the following:
  - 1st missed appointment $35, even though you do not attend the session.
  - Any appointments missed after the "1st missed appointment" you will be charged the full amount of your appointment, even though you do not attend the session.
  - I am unable to charge your insurance for missed appointments so you will be responsible for paying the amount due.
- **Credit Card on File:** I require a current credit card to be kept on file for each patient. The patient acknowledges that this credit card will be charged in the event of a missed/rescheduled appointment not cancelled at least 24 hours ahead of time.
  Credit Card number_____ Expiration Date_____

  CVV/CVC Code (*3 digit code on back of card)* _____ Cardholder's Zip Code_____
- **Payment:** I take BCBS PPO and HMO insurance plans, and will file insurance claims for you if you have this plan. However, for any reason your insurance does not pay for the claim it is your responsibility to pay for my services. **Please call and check your insurance coverage prior to our session so you are aware of what your plan covers.** I do not take any other insurance plans, but if desired can provide a Super Bill for you to file a claim with your insurance company. If you do not have BCBS PPO/HMO insurance plans I take all payment prior to your appointment. It's the responsibility of the client to pay the full amount for services. I take the following forms of payment: cash, Visa, MasterCard, American Express, Discover, JCB, or UnionPay credit cards or debit (processed like credit).
- **HIPAA:** I understand Kati Joyner MA, RDN, LDN, CEDRD-S abides by HIPAA Privacy Guidelines. I understand that a copy is available for patients to review. I understand that I may request a copy of the Notice of Privacy Practice at any time.
- **Patient Responsibilities and Permissions:**
  - It is the responsibility of the patient to confirm any and all exercise and nutrition recommendations with their health care providers.
  - I give permission for Kati Joyner MA, RDN, LDN, CEDRD-S to leave a voice mail if needed with the phone numbers I listed on my New Patient Form.
  - At the time of my nutrition session, if there is a food exposure, taste testing, or restaurant outing offered, I participate per my own wishes and do not hold Kati Joyner MA, RDN, LDN, CEDRD-S liable for anything.
  - I agree to be seen as a patient with Kati Joyner MA, RDN, LDN, CEDRD-S and agree to the above policies to the best of my knowledge, the information I share with Kati Joyner MA, RDN, LDN, CEDRD-S is correct.

I HAVE READ AND I COMPLETELY UNDERSTAND ALL OF KATI JOYNER'S POLICIES AS STATED ABOVE.

Signature _____Date _____/_____/_____

Food Recall

Please be as specific and honest as possible, and include all beverages, condiments, and portion sizes. The Food Recall is meant to give me an idea of your daily intake so I can best support you during our sessions. No judgments will be made from this information. Thank you!

Day 1

Food Item	**Serving Size**	**Time Consumed**	**Where**

Food Recall

Please be as specific and honest as possible, and include all beverages, condiments, and portion sizes. The Food Recall is meant to give me an idea of your daily intake so I can best support you during our sessions. No judgments will be made from this information. Thank you!

Day 2

Food Item	Serving Size	Time Consumed	Where

Food Recall

Please be as specific and honest as possible, and include all beverages, condiments, and portion sizes. The Food Recall is meant to give me an idea of your daily intake so I can best support you during our sessions. No judgments will be made from this information. Thank you!

Day 3

Food Item	Serving Size	Time Consumed	Where

Authorization for Release of Confidential Information

I, _____ of _____
(Street Number & Address)

_____
(City, State) *(Zip Code)*

Authorize: Kati Joyner MA, RD, LDN, CEDRD-S; Phone (910) 899-0227, Fax (910) 839-9018
☐ To Obtain information
☐ To Release information

Exchange information with:

_____
_____
_____
_____

Information from my confidential record to:
☐ Verbal Exchange
☐ Electronic Exchange
☐ Discharge Summary
☐ Admission Evaluation
☐ History & Physical
☐ Progress Notes
☐ Physician Orders
☐ Laboratory Results
☐ Treatment Plan & Summary

I understand that my records are confidential and will not be disclosed without my written consent unless under legal compulsion. I also understand I may revoke this authorization at any time (except retroactively) and, if not revoked earlier, this authorization will automatically expire one year from today. I certify that this form has been fully explained to me and that I understand its contents.

_____
Date Signature of Client Signature of Parent/Guardian

_____
Date Signature of Clinician

Sign below only if you wish to Refuse or Revoke your authorization

_____
Date Signature of Client Signature of Parent/Guardian