



**REZULTS by Renée, LLC ~ Medical Nutrition Therapy (MNT)**  
**Renée J. Bordeaux, RD, CDN, CPT**  
**1100 New Britain Avenue, Suite #104 ~ West Hartford, CT 06110**  
**Phone: 860-978-9449 ~ Fax: 860-523-0141**

### **PATIENT REGISTRATION INFORMATION**

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_

ADDRESS \_\_\_\_\_ City \_\_\_\_\_ ST \_\_\_\_\_ Zip \_\_\_\_\_

E-mail \_\_\_\_\_ BIRTHDATE \_\_\_\_/\_\_\_\_/\_\_\_\_ AGE \_\_\_\_\_ M or F

PHONE (H) \_\_\_\_\_ (C) \_\_\_\_\_ Marital Status: M S Other \_\_\_\_\_

EMERGENCY CONTACT NAME, RELATION, PHONE: \_\_\_\_\_

PRIMARY DOCTOR \_\_\_\_\_ PCP Phone/Address \_\_\_\_\_

SPECIALISTS/THERAPISTS/PSYCHIATRIST (Name, Phone/Address if known) \_\_\_\_\_

How were you referred? Doctor Ad Friend/Family Internet Insurance Other \_\_\_\_\_

PATIENT EMPLOYER \_\_\_\_\_ OCCUPATION \_\_\_\_\_

STUDENT? FT or PT Name of school: \_\_\_\_\_

### **PRIMARY INSURANCE**

Policy Holder's NAME: \_\_\_\_\_ Policy Holder's Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code: \_\_\_\_\_ Telephone: ( ) \_\_\_\_\_ Holder's DOB: \_\_\_\_\_ M or F ?

Ins. Co. and ID #: \_\_\_\_\_ Group No: \_\_\_\_\_

Policy Holder's Employer: \_\_\_\_\_ Patient relationship to insured: Self Spouse Child Other

### **SECONDARY INSURANCE**

Policy Holder's NAME \_\_\_\_\_ Policy Holder Birth date \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip code: \_\_\_\_\_ Telephone: ( ) \_\_\_\_\_ Holder's DOB: \_\_\_\_\_

Ins. Co. and ID #: \_\_\_\_\_ Group No: \_\_\_\_\_

Policy Holder's Employer: \_\_\_\_\_ Patient relationship to insured: Self Spouse Child Other

You authorize Rezults by Renée, LLC to treat you and bill for your medical nutrition therapy visits. We have a 24 hour cancellation policy. Please call if needing to cancel. You may be responsible for the full appointment fee. Insurance will not cover for missed appointments. Thank you.

**SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

**Parent/Guardian** \_\_\_\_\_ **DATE** \_\_\_\_\_



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**NOTICE OF HIPAA PRACTICES**

*(Please see full policy on page 6)*

I acknowledge receiving a copy of the Notice of Privacy Practices of RESULTS by Renée, LLC, Nutrition Consulting, Medical Nutrition Therapy (MNT). If patient read the Notice of Privacy Practices but refused to keep a copy, check here ( )

Signature of patient or authorized representative \_\_\_\_\_

**RESPONSIBILITY FOR PAYMENT**

I, \_\_\_\_\_, understand that RESULTS by Renée, LLC, Nutrition Consulting, Medical Nutrition Therapy (MNT) may bill me for services rendered, if my insurance company or Medicare fails to assign payment to RESULTS by Renée, LLC, Nutrition Consulting, Medical Nutrition Therapy (MNT) *despite prior approval of services. I agree to be fully and personally responsible for payment.* RESULTS by Renée, LLC, Nutrition Consulting, Medical Nutrition Therapy (MNT) agrees to refund me any duplicate payments.

Signature of patient or authorized representative \_\_\_\_\_

**AGREEMENT TO MAINTAIN SIGNATURE ON FILE FOR COMMUNICATIONS WITH  
MEDICARE AND / OR PRIVATE INSURANCE**

Signature of patient or authorized representative \_\_\_\_\_

I HEREBY,

- I. CERTIFY THAT I HAVE RECEIVED or declined A COPY OF THE HIPAA PRIVACY NOTICE (*see page 6*).
- II. AUTHORIZE INSURANCE AND / OR MEDICARE PAYMENTS TO BE SENT TO RESULTS by Renée, LLC, Nutrition Consulting, Medical Nutrition Therapy (MNT) as APPLICABLE.
- III. CERTIFY THAT I AM FINANCIALLY RESPONSIBLE FOR ALL SERVICES RENDERED TO ME AND /OR MEMBERS OF MY FAMILY IF INSURANCE OR MEDICARE FAILS TO ASSIGN PAYMENT OR IS NOT APPLICABLE. I CERTIFY THAT PAYMENT WILL BE MADE WITHIN 30 DAYS.
- IV. I CERTIFY THAT I HAVE RECEIVED AND AGREE TO THE PRACTICE POLICIES (*see page 5*).
- V. I CERTIFY THAT I WILL BE RESPONSIBLE FOR COPAYMENTS DUE AT THE TIME OF SERVICE. IF I AM NOT ABLE TO PAY COPAYMENT AT THE TIME OF SERVICE, I CERTIFY THAT I WILL ARRANGE PAYMENT OF THE COPAYMENT WITHIN A WEEK FROM THE VISIT. 100% OF VISIT WILL BE CHARGED FOR APPOINTMENTS NOT CANCELLED WITHIN 24 HOURS OF VISIT, UNLESS IN CASE OF EMERGENCY.

SIGNATURE \_\_\_\_\_ DATE \_\_\_\_\_

Parent/Guardian \_\_\_\_\_ DATE \_\_\_\_\_

**PATIENT NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

FOR RD USE ONLY

IBW: \_\_\_\_\_ % IBW \_\_\_\_\_ ABW: \_\_\_\_\_ BMI: \_\_\_\_\_

KCAL NEEDS: \_\_\_\_\_ / \_\_\_\_\_ kcals / kg

**PLEASE COMPLETE THE FOLLOWING QUESTIONS:**

WHAT ARE YOUR PERSONAL NUTRITION GOALS? \_\_\_\_\_

\_\_\_\_\_

Have you ever worked with a RD? \_\_\_\_\_ If yes, who: \_\_\_\_\_

**HEALTH STATISTICS**

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_ USUAL WEIGHT \_\_\_\_\_ LAST DATE AT UW \_\_\_\_\_

PATIENT'S GOAL WEIGHT \_\_\_\_\_ HIGHEST WEIGHT \_\_\_\_\_ LOWEST \_\_\_\_\_

ANY SIGNIFICANT WEIGHT CHANGES OVER THE PAST 6 MONTHS? \_\_\_\_\_

PARTICULAR ETHNIC/RELIGIOUS DIETARY PRACTICES? \_\_\_\_\_

LIST ANY FOOD ALLERGIES / INTOLERANCES \_\_\_\_\_

MEDICAL HISTORY INCLUDING ILLNESS, DIAGNOSES, and SURGERIES: (Also list family history of major illness, i.e., diabetes, cardiovascular disease, thyroid dysfunction, etc.)

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

MEDICATIONS \_\_\_\_\_

\_\_\_\_\_

VITAMIN / MINERAL SUPPLEMENTS AND HERBAL PREPARATIONS \_\_\_\_\_

\_\_\_\_\_

WHO DOES THE COOKING? \_\_\_\_\_ SHOPPING? \_\_\_\_\_ WHERE? \_\_\_\_\_

WHAT ARE YOUR FAVORITE FOODS? \_\_\_\_\_

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**PATIENT NAME:** \_\_\_\_\_ **DOB:** \_\_\_\_\_

DO YOU DRINK ALCOHOL? \_\_\_\_\_ IF YES, WHAT KIND, HOW OFTEN AND HOW MUCH AT THAT TIME?

DO YOU EXERCISE? IF SO WHAT, HOW LONG AND HOW OFTEN? \_\_\_\_\_

HOW MANY TIMES A WEEK DO YOU DINE OUT OR PURCHASE FAST FOOD? (Including breakfast, lunch, dinner, beverages, etc.) WHERE?

WHAT FOODS DO YOU DISLIKE? \_\_\_\_\_

BRIEF HISTORY OF EATING D/O BEHAVIOR as applicable. (When started, behaviors, triggers, etc.)

**USUAL DIETARY PATTERN (As best as you can)**

**Please be as specific as possible. Include all beverages, condiments, and portion sizes.**

<b>Time</b>	<b>Food Item and Method of Preparation</b>	<b>Amount Eaten</b>	<b>Where</b>



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*~ PLEASE MAINTAIN THIS COPY FOR YOUR RECORDS ~*

### PRACTICE POLICIES

In order to meet your needs and provide you the best possible care, please honor the following guidelines:

1. Please respect your Dietitian's appointment time limits and be aware that initial appointments typically last from 1.5-2 hours. Follow up visits last ~ 1 hour. We typically schedule clients one right after the other. If you are more than 15 minutes late, we may need to reschedule you and you will be charged for the missed visit. Please call ahead if you may be a few minutes late. Thank you.
2. Please have your doctor send/fax a referral to us prior to your first visit if you are using your insurance company to pay for your visits OR you are a Medicare patient. Referrals must include the following statement: **"Medical Nutrition Therapy for...(your diagnosis)", the doctor's full name and UPIN/NPI number. The referral may be written on the doctor's prescription pad or office stationery and faxed to our office at 860-523-0141.**
3. Please have your current insurance or Medicare card(s) available on your first visit and to make available any new cards as you may receive them.
4. You must pay your co-pay, coinsurance or cost of visit when services are rendered. Payment options are cash, check, debit and credit (VISA, MC, Discover).
5. All outstanding balances will be billed to you. Late fees will be incurred after 30 days. Your account will be sent to collection if not received in 45 days and will include any collection and late fees you have incurred.
6. You must complete and sign a Patient Registration Form with accurate information including that of your spouse or parent if they are the policy holder. Please complete the registration documents prior to your first visit.
7. Please record the date and time of your appointment. You will be charged the full amount of your visit if you miss your appointment or if you do not cancel within 24 hours. Extenuating circumstances and inclement weather will be considered. Please call to discuss your needs.
8. Bring copies of your most recent lab values or ask your doctor to fax them to us prior to your first visit, if available (preferred but not required). Fax: 860-523-0141
9. We look forward to meeting you and assisting with your nutritional wellness needs!



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## **Our HIPAA Policies and Practices**

Keeping our client's personal health information secure is a top priority for us at RESULTS by Renée, LLC, Nutrition Consulting, Medical Nutrition Therapy (MNT). While information is the cornerstone of our ability to provide superior MNT services, our most important asset is our client's trust. This notice tells you how we collect, handle, and disclose personal health information about you. **If you want to limit our disclosure of this information, please submit your wishes to us in writing.**

We protect personal health information we collect about you by maintaining physical, electronic, and procedural safeguards that meet or exceed applicable law.

### **Protected Health Information (PHI)** **We Collect and May Disclose**

The protected health information we collect about you comes from the following sources:

- Information received from your physician or other healthcare provider.
- Information we receive from you while providing MNT services and on enrollment forms, assessment surveys, or other forms.
- Information we receive from other sources such as caregiver, insurer, employer and other third parties.

We may disclose any of your protected health information to the following entities as long as this information is directly related to health services or your individual care. These entities include doctors, hospitals, health care providers, pharmacies, insurance companies, family members or other persons involved directly in your individual care.

Protected health information will not be used for marketing, except if the communication is by a RESULTS by Renée, LLC, Nutrition Consulting, Medical Nutrition Therapy (MNT) staff member directly to you or to provide you with education or promotional material from us. PHI also includes when RESULTS by Renée, LLC, Nutrition Consulting, Medical Nutrition Therapy (MNT) is required to disclose information without your consent such as emergencies, by order of court, criminal activity, etc.