

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

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 _____

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

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 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 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 liable for anything.
 - I agree to be seen as a patient with Kati Joyner MA, RDN, LDN, CEDRD and agree to the above policies to the best of my knowledge, the information I share with Kati Joyner MA, RDN, LDN, CEDRD is correct.

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

Signature _____ Date ____/____/____