ROBYN A. COTLER, MS,RD,CDN
700 OLD COUNTRY ROAD
SUITE 204
PLAINVIEW, NEW YORK 11803
516.433.9496
COTLERNUTRITION@GMAIL.COM

NAME: _____
(LAST) (FIRST)

ADDRESS: _____
(#) (STREET NAME) (CITY) (ZIP CODE)

EMAIL ADDRESS:
_____

HOME PHONE:_____ CELL PHONE:_____

DATE OF BIRTH:_____

REFERRING DOCTOR/ADDRESS/PHONE#:

NAME OF **PRIMARY INSURANCE** COMPANY:

PRIMARY INSURANCE ADDRESS:
_____
(STREET #) (STREET NAME) (CITY) (STATE) (ZIP CODE)

PRIMARY INSURANCE ID#: _____
SECONDARY INSURANCE: _____
ADDRESS: _____
ID#: _____

PRIVACY CONSENT, AUTHORIZATION FOR TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS:

I AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS THIS CLAIM. I PERMIT A COPY OF THIS AUTHOIZATION TO BE USED IN PLACE OF THE ORIGINAL. I AGREE TO PAY ***ROBYN A. COTLER, MS,RD,CDN*** IN A TIMELY AND CURRENT MANNER ANY BALANCE OF MEDICAL CHARGES AND EXPENSES SUCH AS SERVICES NOT COVERED BY INSURANCE PLAN, COPAYS AND/OR DEDUCTIBLES THAT ARE THE PATIENT'S RESPONSIBILITY – YOU MUST PRESENT THE REFERRAL FORM AT THE TIME OF VISIT. **ONLY CASH OR CHECKS ACCEPTED**

MEDICARE B PATIENTS: "I REQUEST THAT PAYMENT OF AUTHORIZED MEDICARE BENEFITS BE MADE TO ROBYN A. COTLER, MS, RD, CDN FOR ANY SERVICES FURNISHED TO ME. I AUTHORIZE ANY HOLDER OF MEDICAL INFORMATION ABOUT ME TO RELEASE TO THE HEALTH CARE FINANCING ADMINISTRATION AND ITS AGENTS ANY INFORMATION NEEDED TO DETERMINE THESE BENEFITS OF THE PAYABLE FOR RELATED SERVICES."
IN ADDITION, MEDICARE PATIENTS ARE AWARE THAT MEDICARE IN MOST CASES WILL REIMBURSE ONLY FOR THREE (3) ONE (1) HOUR VISITS/YEAR FOR DIABETES (ONLY). PT INITIALS _____

I HAVE RECEIVED A COPY OF THE MOST CURRENT NOTICE OF PRIVACY PRACTICES. INITIAL:_____

PATIENT'S SIGNATURE: _____ DATE: _____

MEDICAL HISTORY:

SURGERIES (PLEASE LIST DATES):

_____

HT: _____ CBW: _____ BMI: ____ WEIGHT HISTORY: _____

FOOD ALLERGIES: _____

RECENT LAB DATA: CHOLESTEROL: LDL: HDL: TG: HGA1C:

FASTING BLOOD SUGAR: BP: CRP: SLEEP:

OTHER MEDICAL: _____

_____

CURRENT MEDICATIONS:

_____

_____

VITAMIN/MINERAL SUPPLEMENTS (LIST DOSE):

_____

_____

_____

DO YOU SMOKE? IF YES, HOW MUCH? _____

WEEKLY ALCOHOL INTAKE: _____

REASON FOR VISIT:

_____

_____

REFERRING DOCTOR: _____

REFERRING DOCTOR PHONE & ADDRESS: (_____)_____

_____

DIRECTIONS: LIE TO EXIT 44 S. TAKE TO OLD COUNTRY ROAD EXIT. MAKE RIGHT ONTO OLD COUNTRY ROAD. DRIVE APPROXIMATELY ½ MILE. BUILDING WILL BE ON RIGHT. **CHECK IN WITH THE RECEPTIONIST!!!**

COTLER NUTRITION CONSULTING SERVICES
ROBYN A. COTLER, MS,RD,CDN
700 OLD COUNTRY ROAD
PLAINVIEW, NY 11803
516-433-9496

Effective date: JUNE 2010

No Show/Cancellation Policy

Once an appointment is scheduled, you are expected to pay out of pocket for the full fee, equivalent to that reimbursed for attended appointments, unless you provide 36 hours advanced notice of cancellation. The fee is $50.00 out of pocket.

Leave notice of cancellations on my voice mail at:

516.433.9496

OR EMAIL:

COTLERNUTRITION@GMAIL.COM

Patient Signature: _____ **Date:** _____

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*Current Fees: August 2012

Initial Nutrition Visit (55 minutes)- $250.00

Initial Nutrition F/U (45 minutes)- $200.00

Secondary Follow up Visit (35 minutes)- $175.00

Monthly visits (30 minutes)- $125.00

Weekly Weigh In Visits (20 minutes): $60.00

Weight Loss Package:

First 3 visits plus 1 weigh in visit: $600.00 (must be paid up front)

*Fees are pending on Health Insurance Policy. Should health insurance policy cover medical nutrition therapy above fees are null and void.