



## The Seattle Arthritis Clinic

Hello!

Enclosed is a packet of information for you to fill out and bring with you to your appointment. But first, a few important details before we meet:

### **Information for the day of your appointment**

1. Items to bring with you:
  - The attached forms (completed and signed)
  - Picture ID
  - Insurance card (if using)
  - Co-pay or cash payment (I accept cash and checks only, no credit cards accepted)
  - Prior medical information including relevant lab results or additional paperwork that you feel would be helpful for me to know.

### **Insurance and Payment Information**

1. If you're using insurance, know your benefits!! Please contact your insurance carrier *prior* to your first appointment to ensure you are covered for your visit. Cash rates are discounted at the time of service (\$135 for initial session, \$90 for follow-ups) and are, therefore, less than the contracted rate with insurance companies. Should your claim be denied by your carrier, or your annual deductible is not yet met, you will be responsible for the full insurance rate (\$315 for initial, \$180 for follow-ups).
2. When contacting your insurance company be sure to ask the following:
  - “Does my plan cover visits with Nutrition professionals?” Provide them with the CPT Code: 97802
  - Most plans will not cover for weight loss issues, but will cover other diagnoses. Be sure to provide them the diagnosis from your doctor (Rheumatoid Arthritis, Fibromyalgia, IBS, hypercholesterolemia, etc.), or, if no diagnosis, symptoms being experienced (heartburn, constipation, fatigue, muscle pain, etc.).
  - “Do I need a referral from a doctor in order to see a Dietitian?” If so, contact your family doctor or referring provider.
  - “Is there a limit to the number of visits I can attend over the calendar year or in a lifetime? When does my plan's calendar year end/begin?”
  - Keep record of the time, date and name of the rep providing information.
3. If you have Medicare as your primary provider, note that I am not a Medicare provider; however, if your secondary insurance provides benefits for the service, we will bill Medicare for the refusal and submit to your secondary insurance plan. Be sure to contact your secondary insurance company to confirm coverage.

### **Cancellations**

If you need to cancel your initial or follow-up appointments, please provide a 48 hour notice to avoid incurring the full session fees (\$135/\$90 respectively). You can contact The Seattle Arthritis Clinic for any scheduling needs.

Many thanks, and I very much look forward to meeting you!

Heidi Turner, MS, RD, CD



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**Personal Information**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Birth date: \_\_\_\_\_ Sex: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home Phone: \_\_\_\_\_ Work : \_\_\_\_\_ Cell : \_\_\_\_\_

Email: \_\_\_\_\_ Occupation: \_\_\_\_\_

Physician contact: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Where did you hear about the service? \_\_\_\_\_

Please list your health concerns in order of importance:

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_ 4. \_\_\_\_\_

**Medications and Supplements**

Current Medications (or attach list)

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Current Supplements and dosages:

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**Physical Activity**

Do you exercise? If not, please explain contributing factors:

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If so, what type of exercise?

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How often and for what duration do you exercise?

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**Food Intolerances or Allergies**

Do you have any known food allergies? If so, please list and explain effect: \_\_\_\_\_

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Are there any foods you avoid and/or dislike? \_\_\_\_\_

\_\_\_\_\_

Are there any foods you crave? \_\_\_\_\_

\_\_\_\_\_

### **Gastrointestinal Health**

Please circle the following if you experience *regularly*. Include frequency and severity:

Gas \_\_\_\_\_

Bloating \_\_\_\_\_

Constipation \_\_\_\_\_

Diarrhea \_\_\_\_\_

Heartburn \_\_\_\_\_

Nausea or vomiting \_\_\_\_\_

\_\_\_\_\_

### **Weight History**

Are you currently taking or have you taken part in a weight loss program or diet? If so, explain:

\_\_\_\_\_

\_\_\_\_\_

Is your weight stable or does it fluctuate? \_\_\_\_\_

Have you recently gained or loss a significant amount of weight (10# or more)? \_\_\_\_\_

Do you have a history of emotional eating (eating in response to emotion)? \_\_\_\_\_

Do you have a history of an eating disorder? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_



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**Family Health History** (Check S for self, F for father, M for mother, Si for sibling, G for grandparent)

- \_\_\_ Alcoholism      \_\_\_ Anemia              \_\_\_ Arthritis              \_\_\_ Asthma
- \_\_\_ Bowel disease      \_\_\_ Cancer              \_\_\_ Celiac Sprue              \_\_\_ Crohn's
- \_\_\_ Depression      \_\_\_ Diabetes              \_\_\_ Eating Disorders      \_\_\_ Food Allergies
- \_\_\_ Heart Disease      \_\_\_ High Blood Pressure              \_\_\_ Hypoglycemia
- \_\_\_ Liver Disease      \_\_\_ Skin rashes              \_\_\_ Sinus issues              \_\_\_ Thyroid

Please list any other significant health issues you feel I should be aware of:

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**Social and Nutritional Habits**

On a scale of 1-10, rate your average level of stress (1=relaxed/10=stressed) \_\_\_\_\_

Have you noticed your pain or physical symptoms increase the more stressed you are?

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On a scale of 1-10, rate your average level of energy (1=low/10=high) \_\_\_\_\_

History of smoking? For how long, number of packs per day, and if you've quit, when?

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Do you live alone or with others? \_\_\_\_\_

At which stores do you shop for food? \_\_\_\_\_

Who does the shopping/cooking? \_\_\_\_\_

Do you like to cook? \_\_\_\_\_

How many times per week and where do you typically eat outside of the home?

	<u>Frequency</u>	<u>Location(s)</u>
Breakfast	_____	_____
Lunch	_____	_____
Dinner	_____	_____



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### **Diet History**

Please provide a 3-day food history, including 2 weekdays and 1 weekend day. If you're experiencing pain or gastrointestinal issues, include any symptoms that you experience as well, and note the times. Be specific and try not to change what you eat through the process. Include beverages and any snacks. *Note: if time does not allow you to fill in the form prior to the appointment, we will cover off-form in session.*

Day 1:

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Time	Food Eaten	Symptoms

How much water did you drink today?

What other fluids and amounts did you drink today?

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Day 2:

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Time	Food Eaten	Symptoms

How much water did you drink today?

What other fluids and amounts did you drink today?

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Day 3

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Time	Food Eaten	Symptoms

How much water did you drink today?

What other fluids and amounts did you drink today?

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Financial Agreement

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Policies

Northwest hospital will bill your insurance company for the entire session fee. The client is responsible for all payment or billings not covered by the insurance company including co-pays, co-insurance and unpaid annual deductibles.

Form of Payment

Cash and personal checks are an accepted form of payment for co-pays and session fees. Credit cards are not accepted.

Cancellation Policy

A 48 hour cancellation notice is required for all appointments. If appropriate notice is not given, the client will be responsible for the full session fee. Please note that clients who use insurance to pay for their sessions will be responsible for full cash payment (\$135 for initial sessions, \$90 for follow-ups).

Acceptance and Understanding of Policies

Please initial the following:

\_\_\_\_\_ I understand that I will be charged in full for cancellations not made within 48 hours of the scheduled appointment time. If my insurance typically pays for the session, I will be responsible for the full cash payment.

\_\_\_\_\_ I understand that payment (cash or co-pay) is due at the time of session in the form of cash or check.

\_\_\_\_\_ I understand that I am responsible for all payments or billings not covered by my insurance plan.

\_\_\_\_\_ I understand that should my insurance deductible not be met for the calendar year, I will be responsible for the full session fee of \$320 (amount will be applied towards your annual deductible).

Signature

Date

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Patient Privacy

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\* For patients referred by a practitioner at the Seattle Arthritis Clinic

Unless otherwise directed, if you are an existing patient with the Seattle Arthritis Clinic, a copy of the initial chart note will be automatically given to your referring provider in an effort to build our model of integrated care. Please circle which you would prefer:

**“I would / would not like Heidi Turner, RD to review my records and discuss my health and treatment with my referring medical provider at the Seattle Arthritis Clinic.”**

In addition, please note any exceptions or additional outside providers to which you would like a progress note sent on your behalf:

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\* For clients not referred by the Seattle Arthritis Clinic

If you are self-referred or referred by a practitioner outside of the Seattle Arthritis Clinic, please indicate if you would like your healthcare provider contacted about the session today.

**“I would / would not like Heidi Turner, RD to review my records and discuss my health and treatment with my referring medical provider.”**

Please note your provider’s contact information including name and telephone number here.

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Signature

Date

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Heidi Turner, MS, RD, CD

Pre-payment Form

For patients who are paying cash, pre-paying for multiple sessions can be more cost-effective than paying as you go.

**Pre-paid Session Rates**

For New Clients

3 sessions (1 initial and 2 follow-ups)	\$295
5 sessions (1 initial and 4 follow-ups)	\$450
8 sessions (1 initial and 7 follow-ups)	\$695

For Returning Clients

3 sessions	\$250
5 sessions	\$400
8 sessions	\$650

Weight Loss Package

8 in-office sessions, supplementation, 2 hour grocery-store shopping tour \$995

Prepayment Policies

*Sessions must be used within 1 year of the date of purchase. Payments due on the first date of service by cash or check only. You can postpone payment until immediately after the first session when a plan of care is agreed upon.*

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