Patient Information

Name:_____ Cell Phone Number:_____

Address:_____

City:_____State/Zip Code:_____

Telephone: (Home): _____Telephone: (Work or Pager):_____

Telephone: (Fax):_____ e-mail: _____

Date of Birth: _____ Sex: M F (circle one) Marital Status: M W D S (circle one)

Employer:_____

Primary Physician:_____

Who referred you?_____

Person to contact in emergency:_____Emergency telephone:_____

Special needs:_____

Responsible Party

Party Responsible for Payment: Self Spouse Parent Other

Name (if other than self):_____

Address:_____

City:_____State:_____Zip Code:_____

Primary Insurance

Primary Medical Insurance:_____

Insured Party: Self Spouse Parent Other

Insured Name (if other than self):_____+_____

Insured ID#/:_____Group/Plan No.:_____

Address:_____

City:_____State:_____ Zip Code:_____

Secondary Insurance

Secondary Medical Insurance:_____

Insured Party: Self Spouse Parent Other

Insured Name (if other than self):_____

Insured ID#/:_____Group/Plan No.:_____

Address:_____

City:_____State:_____Zip Code:_____

Office Policy: All incurred charges are due and payable at the time of service. I understand that I am financially responsible to the dietitian for the charges incurred by myself and/or my dependents. Please note that Medicare will not reimburse either the dietitian or the patient for services rendered by this office. Insurance information is being requested only to facilitate correspondence should it become necessary.

Date:_____Signature:_____

Name: _____

1. Reason(s) for visit:_____

   _____

   _____

2. Do you have any medical condition(s)? □ Yes □ No

Type	Time of Onset

3. Do you have any food allergies or aversions? □ Yes □ No If yes, please list:

   _____

   _____

4. Do you take any prescription medications? □ Yes □ No

Name	Dose	Time of Day	Reason For Taking

5. Do you take over-the-counter medications or vitamins? □ Yes □ No

Name	Dose	Time of Day	Reason For Taking

Name:_____

6. What do you drink?

Type	Amount per Day
Water	
Milk	
Alcohol	
Caffeinated soft drinks, coffee, or tea	
Decaffeinated soft drinks, coffee, or tea	

7. Do you smoke? □ Yes □ No Amount:_____

8. Do you salt your food? □ Freely □ Sparingly □ Not at All.

9. Do you exercise? □ Yes □ No

Type(s)	Frequency	Duration

10. Have you ever followed a special diet? □ Yes □ No

Type	Date	Success more than 1 year?
		□ Yes □ No
		□ Yes □ No
		□ Yes □ No

11. **If your are pregnant:** Due Date: _____ Prepregnancy Weight: _____
Number of Previous: Pregnancies: _____ Children:_____

Will you be breastfeeding? □ Yes □ No How long? _____

12. **If you have diabetes:** Type:_____ Date of Onset: _____
Do you test your blood sugar? □ Yes □ No How many times per day? _____
Type of meter used: _____ Usual readings: _____

Do you have any complications? □ Yes □ No If yes, please list:_____

_____

_____

Name: _____

24-HOUR DIET HISTORY

PLEASE DESCRIBE, TO THE BEST OF YOUR ABILITY, THE FOODS YOU TYPICALLY CONSUME IN A 24-HOUR PERIOD. TRY TO BE AS DETAILED AS POSSIBLE, INCLUDING SUCH ITEMS AS BUTTER, SALAD DRESSING, CONDIMENTS, AND BEVERAGES.

Meal or Snack	Time Consumed	Amount Consumed	Food or Beverage Item
Breakfast	*7:30 am*	*1 Cup*	*Oatmeal (cooked)*

Mary Alice Volkert and Associates, 6565 West Loop South, Suite 510, Bellaire, Texas 77401, (713) 668-2759

Mary Alice Volkert & Associates
6565 West Loop South, Suite 510
Bellaire, Texas 77401-4111
Phone # 713-668-2759 Fax # 713-668-2762

PRIVATE PATIENT CONTRACT

This agreement is between Mary Alice Volkert & Associates, whose principal place of business is 6565 West Loop South, Bellaire, Texas, 77401 and _____, ("Patient") who resides at _____ and is a Medicare Part B beneficiary seeking services covered under Medicare Part B pursuant to Section 4507 of the Balanced Budget Act of 1997.

Mary Alice Volkert and Associates have informed Patient that Mary Alice Volkert has opted out of the Medicare program effective on April 1, 2013 for a period of at least two years, and is not excluded from participating in Medicare Part B under Sections 1128, 1156, or 1892 or any other section of the Social Security Act.

Mary Alice Volkert and Associates agrees to provide Medical Nutrition Therapy ("Services") to Patient.

In exchange for the Services, the Patient (or his or her legal representative) agrees to make payments to Mary Alice Volkert and Associates pursuant to the attached Fee Schedule. Patient (or his or her legal representative) also agrees, understands, and expressly acknowledges the following and:

- Accepts full responsibility for payment of the practitioner's charge for all services furnished by the practitioner.
- Understands that Medicare limits do not apply to what the practitioner may charge for items or services furnished by the practitioner.
- Agrees not to submit a claim to Medicare or to ask the practitioner to submit a claim to Medicare.
- Understands that Medicare payment will not be made for any items or services furnished by the practitioner that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.
- Enters into this contract with the knowledge that he or she has the right to obtain Medicare-covered items and services from practitioners who have not opted-out of Medicare, and that the beneficiary is not compelled to enter into private contracts that apply to other Medicare-covered services furnished by other physicians or practitioners who have not opted out.

- Understands that Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

- This contract may not be entered into by the patient (or his or her legal representative) during a time when the patient requires emergency care services or urgent care services.

_____	_____
Patient Name *(Please Print)*	Mary Alice Volkert
_____	_____
Patient Signature	Date
_____	
Date	

Mary Alice Volkert & Associates
6565 West Loop South, Suite 510
Bellaire, Texas 77401-4111
Phone # 713-668-2759 Fax # 713-668-2762

Fee Schedule

(All Payments Due at Time of Service in Form of Cash or Check)

Initial Visit (1-1/2 or 2-hour consultation):	$320
Two Individuals Each Seeking Personal Assessment at the Same Appointment:	$420
Follow-up Visits (1-hour consultation):	$160
Follow-up Visits (Two Individuals, 1-hour consultation)	$195
Insulin Management	$160
Failure to Cancel within 24 hours	$25

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Bellaire, TX 77401-4111
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_____, MD
_____
_____
_____

Dear Dr. _____,

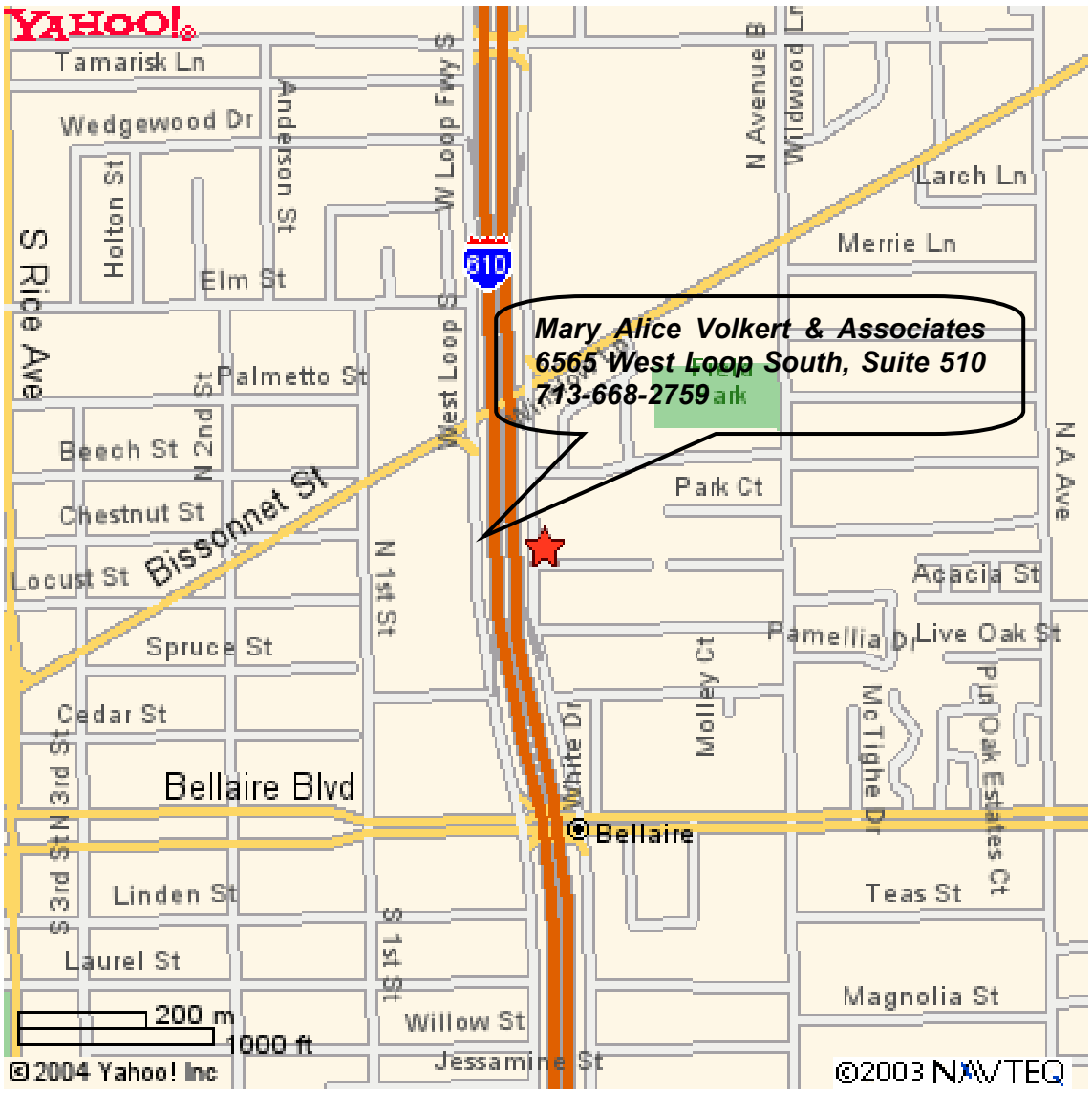
I, _____, hereby release any medical records or laboratory work to **Mary Alice Volkert**, **MS, RD, LD,** for my appointment.

Sincerely,

_____ _____
Patient's Signature Date

Mary Alice Volkert & Associates

6565 West Loop South, Suite 510
Bellaire, Texas 77401
Phone (713) 668-2759 Fax (713) 668-2762



The office is located at **6565 West Loop South, Suite 510, in Bellaire. Take the "Bellaire" exit (going either direction) and head north on the feeder towards Bissonnet.** Our location is the north building of a pair of 8-story black glass "boxes" on the Loop 610 northbound feeder road. Visitor parking is free and plentiful around the buildings, and there is more free covered parking in the garage behind the buildings. An elevator is available on the south end of the garage.

We look forward to seeing you soon!