CHERNUS NUTRITION, PLLC
Andrea Chernus, M.S., R.D., C.D.E., C.S.S.D.
133 W. 72nd St. Suite 703 New York, NY 10023
Phone: 212-579-7070 Fax: 212-579-9581 e-mail: arc@ChernusNutrition.com

Thank you for making an appointment with Chernus Nutrition, PLLC. Andrea Chernus welcomes you as a new patient and looks forward to helping you achieve the results you desire.

- Please read all information, and fill out all forms completely. Please be sure to submit them *prior* to your appointment, so that your scheduled time may most beneficial to you.
- Your appointment is a reservation for a specific time slot. Only one person is seen at a time, and we adhere to our schedule. Please be ON TIME. If you are late, you will be seen, but the duration of your visit will be shortened.
- You will receive a phone call to confirm your appointment one business day before each visit. If there is any question as to the time or location (there is only one office) please call. If you need to cancel, please give as much notice as you can.
- Cancellations made less than 24 hrs in advance are subject to a $50 fee.
- If you are using health insurance, please read and fill out the following page on health insurance. BRING YOUR CARD TO THE APPOINTMENT.
- Payment is due at the end of each session. Personal checks, cash, most Health Savings Account cards, and personal credit cards: Visa, MasterCard, Discover and American Express are accepted.
- You will be asked for a credit card to be kept on file, to be used in the event insurance does not cover your visit, you have not met your deductible, differences in co-payment or for insufficient cancellation time.
- If you need reading glasses, please bring them with you.
- Please have your physician fax your blood work to 212-579-9581 prior to your visit. This is extremely important for those with Diabetes (including borderline), high cholesterol, eating disorders, kidney disease, thyroid disease, PCOS or anemia.
- Pre-paid sessions must be utilized within 6 months from date of purchase.
- There are no refunds on any services rendered or pre-paid sessions after expiration stated above.

Please fax this page, the following three pages, and the Food and Exercise Journal pages to:

212-579-9581

I have read Chernus Nutrition's office policies and agree to the terms. I understand that if insurance coverage is denied, I am responsible for payment. I understand that I will be responsible for any fees incurred in collecting unpaid balances (bounced checks, attorney, collection agency).

X____Date_______________

Patient Signature

CHERNUS NUTRITION, PLLC
Andrea Chernus, M.S., R.D., C.D.E., C.S.S.D.
133 W. 72nd St. Suite 703 New York, NY 10023
Phone: 212-579-7070 Fax: 212-579-9581 e-mail: arc@ChernusNutrition.com

PATIENT INFORMATION

Name____Date_______________
Home Address____
City________________________________State___________Zip________________
Please supply at least one land – line:
Work Phone_________________Home Phone_________________Cell Phone__________
Date of birth __________________________E-mail:_____________________________
Social Security Number______________________
Marital Status: ☐ Married ☐ Single ☐ Divorced ☐ Separated ☐ Widowed (required for insurance)
Employer______________________________Referred by________________________
Physician's Name____
Physician's Address____
Physician's Phone____

Age_________Height_____________Current Weight____________

What has been your lowest adult weight? ______________ When was this?_______________
What has been your highest adult weight?______________When was this?_______________
Would you like to: Lose weight _____
Gain weight______
Maintain current weight_____

What would you like to accomplish by seeing a nutritionist? Do you have specific goals?
____
____
____

Please circle all that apply to you:

Anemia	Cancer	Diabetes	Heartburn/acid reflux	Hypoglycemia	Overweight
Anorexia	Celiac	Diverticulitis	Heart attack	Irritable Bowel	PCOS
Arthritis	Crohn's	Eating disorder	Hiatal Hernia	Kidney disease	Pre-diabetes
Binge Eating	Colitis	Food allergies	High Blood Pressure	Lactose intolerance	Sleep apnea
Bipolar	Constipation	Gallbladder disease	High Cholesterol	Osteoporosis	Stroke
Bulimia	Depression	Gout	H.I.V.	Obesity	Thyroid

Other (please explain)
____
____

Family History (mark M for mother; F for father)
Cancer______________Heart Attack_________________High Cholesterol_________________
Diabetes_____________High Blood Pressure____________Overweight____________________
Other significant family history____

Please list any prescription medication you are taking, dosage and the condition involved
____
____
____

List any vitamin, mineral and herbal supplements you are taking and dosage if known
____
____
____

CHERNUS NUTRITION, PLLC
Andrea Chernus, M.S., R.D., C.D.E., C.S.S.D.
133 W. 72nd St. Suite 703 New York, NY 10023
Phone: 212-579-7070 Fax: 212-579-9581 e-mail: arc@ChernusNutrition.com

Do you smoke:
Cigarettes: Yes______No______Quit_______how long ago?______________
Cigars: Yes_____No_____
Marijuana: Yes____No____
Do you drink alcohol? Yes____How much/often____________________________No_____
If you exercise, describe your regime including how often and for how long you participate
____
____
____

What time do you go to sleep on week nights? ____________________On week-ends?___________
What time do you wake up on week days? ______________________On week-ends?___________

Have you ever followed any special diet? If so, please describe________________________________
____

Are you currently following a special diet? If so, please describe______________________________
____

List any foods you have an allergy or intolerance to and the symptoms you experience:
____
____
____

List any foods that you intensely dislike or would refuse to eat:
____
____
____

How many times per week do you go out or have take-out food, for:
Breakfast _________Lunch ____________Dinner ___________
How many times per week do you or does someone in your family prepare the following meals:
Breakfast _________Lunch ___________Dinner __________

Do you crave any foods? If so, please specify____
____
____

Is there anything else that you would like me to know about you? ____________________________
____
____

By signing this form, I authorize you to exchange medical information with my Primary Care Provider, listed above. I understand that you respect my privacy, and take all necessary steps to protect the privacy of my medical information. I have received and agree to Chernus Nutrition's HIPAA agreement.

X____Date___________
Patient Signature

CHERNUS NUTRITION, PLLC
Andrea Chernus, M.S., R.D., C.D.E., C.S.S.D.
133 W. 72nd St. Suite 703 New York, NY 10023
Phone: 212-579-7070 Fax: 212-579-9581 e-mail: arc@ChernusNutrition.com

INSURANCE INFORMATION

Read carefully
Fill out all information requested

- You must call your insurance plan prior to your visit to inquire as to whether they cover nutrition counseling and MOST IMPORTANTLY whether they cover for the reason you are seeking help. Obtain a reference number for the call and the name of the person you speak with. Just because your physician suggested that you see Andrea Chernus, does not mean you are automatically covered. A referral is not a guarantee of coverage.
- Andrea Chernus accepts the following insurance plans: Aetna, Blue Cross Blue Shield (PPO only for BCBS), Cigna, GHI, Multiplan, Oxford, PHCS, and United Healthcare. Chernus Nutrition will file the claim for these plans. Every insurance plan is different as to the coverage for nutrition counseling. If services are not covered, you are responsible for payment. If you have a deductible that has not been met, you are responsible for payment directly to Chernus Nutrition. Andrea Chernus will be happy to discuss this with you prior to your visit.
- If you have more than one insurance plan, you must use your primary plan.
- If you need a referral you must obtain one prior to your visit. It must be generated through the Insurance system – just having your physician telling you to see a nutritionist is not sufficient. A referral is not a guarantee of coverage. Be sure to call the insurance company as explained above.
- Certain plans only cover nutrition in a hospital or MD's office. You must ask if this limitation applies to your plan (usually self-funded plans) and ask if Andrea Chernus RD is covered under your plan – you can give the member services office her ID number listed at: www.ChernusNutrition.com

Fill out ALL information:

Primary Insurance:___________________________
ID number__________________________________
Group number_____________________________
Name on card______________________________
If spouse or parent's name is on card please provide their name and date of birth:
____
- Do you need a referral? ☐ Yes ☐ No
- If so, do you have it or have you called your physician to get the referral? ☐ Yes ☐ No
- Do you have a deductible? ☐ Yes ☐ No
- If so, has it been met? ☐ Yes ☐ No
- Did you call your insurance company to find out if nutrition services are covered? ☐ Yes ☐ No

Reference number for telephone call to Insurance ______________________________
Person you spoke to _____________________

Secondary Insurance____________________________
Secondary ID number__________________________
Group number________________________________
Name on card_________________________________
If spouse or parent's name is on card, please provide their name and date of birth:
____
- Do you need a referral? ☐ Yes ☐ No
- If so, do you have it or have you called your physician to get the referral? ☐ Yes ☐ No
- Do you have a deductible? ☐ Yes ☐ No
- If so, has it been met? ☐ Yes ☐ No
- Did you call your insurance company to find out if nutrition services are covered? ☐ Yes ☐ No

Reference number for telephone call to insurance___________________________________
Person you spoke to__________________________