Monina A. Fournier, RD, CLE
Registered Dietitian
2781 W. MacArthur Blvd. Suite B144., Santa Ana, CA 92704
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Registration and Consent Form

Greetings! I am glad to have the opportunity to meet you. As part of your preparation for your weight loss surgery, majority of the bariatric surgeon insist on a nutrition evaluation to assess your readiness and qualification for the surgery. As well as most insurance companies requires a nutrition evaluation report to get approval for the surgery. In order to facilitate a productive relationship, I have set forth certain information which will enable you to make informed consent to counseling

Consultation Appointments: All consultations are usually done through a phone call and are held between 15 to 45 minutes long. Once I receive your completed nutrition evaluation questionnaire, I will contact you at the phone number you provided and time you requested.

Confidentiality: There will be no information about your evaluation that will be released to anyone unless you provide a written authorization. The only exception to this would be if I did not receive payment for services and are sent to collections for payment. Necessary information will be released in order to get paid for services. There are other limits to confidentiality such as:

- Risk of imminent harm to you and another person. It is our responsibility to protect life.
- When the court orders us to release information which we are bound to comply.
- In response to a subpoena from a court or a secretary of law.

Fees and Financial Agreement: Fees for service are due at beginning or prior to the time the service is provided. Forms of payment accepted includes: personal checks, cashier's check and credit cards. Fees are as follows: Initial consultations $ 50.00 for 30 to 45 mins.
Follow-up consults $ 35.00 for 15 to 30 mins.
Payments will be made to Monina A. Fournier at the address stated above. Please indicate method of payment prior to consultation. Checks may be mailed with the nutrition evaluation questionnaire. There will be a $25.00 fee for returned checks. A receipt of payment will be mailed after our consultation. Nutrition counseling services are at times covered by other insurance companies as an out-of-network benefit. If you choose to attempt reimbursement from your insurance company, you may submit the receipt that I have provided. It is your responsibility to research this possibility at your desired time.

Counseling Process: In our effort to produce a satisfactory report, your cooperation in supplying full and honest answers is very important. All forms should only be answered by you. Any questions or concern may be address during our consulting session.

Consent for Consultation

I have read through all the above information and have been clearly advised of my rights and responsibilities. I understand these rights and responsibility and agree to abide by them. I consent to counseling and I understand I have a right to receive a copy of this form upon request.

Patient Name (please print): _____

Signature: _____ Date: _____

General Information:

Patient Name: _____ Birthdate: _____

Mailing Address: _____
_____

Phone Number: _____ Best time to call: _____

Email Address: _____

Payment Method: □ Cash □ Personal Checks □ Cashier's Check □ Credit Card
Credit Card Information (required): □ VISA □ MasterCard
Card Number: _____
Expiration date: _____
CVC number (3 digit code on back of card) _____

Insurance Information:
Name of Insurance Plan: _____
Name of Insured: _____Date of Birth of Insured_____
Address of Insured: _____
Insured ID Number: _____Group ID: _____
Name of Insured's Employer: _____
Phone Number of Insured: _____Co-pays: _____

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Nutrition Evaluation Questionnaire

Name: _____ Age:_____Sex:_____ Date of Birth:_____ Date:_____

1. What weight loss surgery are you planning to have?_____
2. What is your current height and weight? _____
3. How long have you had this weight problem?_____
4. What was your highest adult weight? When was this?_____
5. What was your lowest adult weight? When was this?_____
6. What are your medical problems? □ Diabetes □ High Blood Pressure □ High Cholesterol □ Asthma □ GERD
   □ Sleep Apnea □ Arthritis □ Depression □ Others: _____
7. What are your past diets attempts? □Weight Watchers □ Nutri-System □ Jenny Craig □Lindora □Liquid diet
   □Vitamin B12 shots □Atkins □ South Beach □ fad diets □diet pills
   □ Others:_____
8. Which of these diet attempts resulted to a significant weight loss? _____
9. How much did you lose? _____ How long did you keep it off? _____
10. What do you think contributed to your weight gain? _____
    _____
    _____
11. What are your current eating/drinking habits in a typical day?

    Breakfast:_____
    _____
    Lunch: _____
    _____
    Dinner: _____
    _____
    Snacks: _____
    _____
    Drinks: _____
    _____

12. Do you exercise regularly? What do you do? How often? _____
13. How did your weight problem affect your life? _____
    _____
    _____
    _____

Please read and sign the dietary changes after surgery:

- Eat 3 meals a day and minimize or no snacking.
- Eat protein first at meals, then vegetables and fruits, last carbohydrates like bread and pasta.
- Meal choices are low in fat and sugar
- Chew food well.
- Plan all meals ahead of time.
- Take supplements such as multi-vitamins, calcium, iron and Vitamin B12.
- Avoid alcohol
- Be aware of support groups

_____
Patient's signature