Alice Baland, MA, LPC, RDN
Licensed Professional Counselor
Registered Dietitian Nutritionist

Alice Baland's
Life Solutions Center, LLC
Fax 214-291-5354

PAYMENT FORM

The Nutrition Assessment for your Weight Loss Surgery is conducted by Alice Baland, Registered Dietitian, and an independent contractor for your Weight Loss Surgeon. A pre-payment of $100.00 is required for your Nutrition Assessment. You may pay with Visa or MasterCard payable to Alice Baland. Fax this payment form to Alice's confidential fax at 214-291-5354. Payment must be received 48 hours *before* your Nutrition Assessment appointment. [Ask about her Psych Eval phone consults too. Save driving.]

Alice will call you within 5-10 minutes of the scheduled time, complete your Nutrition Assessment report, and submit your Letter of Clearance to your Weight Loss Surgeon by fax. Please allow 20-30 minutes to complete the assessment. You will receive a receipt that you can submit to your insurance company for possible reimbursement. Alice does not file insurance.

If you miss your scheduled appointment or fail to cancel by phone (214-335-5556) at least 24-hrs in advance, you must pre-pay another $100.00 to reschedule. NOTE: Insurance does not pay for missed appointments. Please be courteous and be on time.

Client Information [Alice will mail your Pre-Post Surgery Diet Guidelines to this address.]

Name:	Appointment Date:	Birthdate:
Street Address:	Appt. Time:	Gender: Male Female
City/State/ZIP:	Home Ph:	Height: Ft. In.
e-Mail:	Work Ph:	Weight: lbs.
Occupation:	Cell Ph:	Highest Weight: lbs.
Referring Surgeon/Physician:	Age	Most Weight Lost: lbs.

Pre-Authorized Health-Care Agreement

Alice Baland, MA, LPC, RDN, has my permission to charge health care fees to my credit/debit card:

VISA MasterCard

Account #: __________/ __________/ ___________/ ___________

Expiration Date: __________/__________ Security Code: _____________

Name/Initial on Account:________________________________

Billing Address: ________________________________

City, ST ZIP: ________________________________

- Nutrition Assessment and any required follow-ups.
- Any sessions missed without 24-hr. phone cancellation
- 3 or 6 month programs personalized for you, if desired.

(Office Use Only)
Authorization Code ________________________________
Date ________________________________

Signature:

Date

Nutrition Assessment Pre-payment

Charge the above credit card: **$**_____________ Add Psych Eval Fee **$**_______________

Nutrition Assessment Schedule (Office Use Only). Combine with Psych Eval by Phone? ______ (Allow 1 Hour).

Date: ____________________________ Time: ____________________________ Phone: ____________________________

Diagnostic Codes (Office Use Only)

ICD#: ____________________________ ICD#: ____________________________ ICD#: ____________________________

ICD#: ____________________________ ICD#: ____________________________ ICD#: ____________________________

Please Complete, Sign, and Fax to: Alice Baland, **Fax: 214-291-5354**, Phone: 214-335-5556. **Thank You!**

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Name: ____ Nutrition Assessment Form

*Please **print legibly** the following Nutrition Assessment. This form is crucial in developing an appropriate treatment plan for you. Please answer the questions as completely as possible. Thanks!*

Medical/Diet History; Eating Disorder Assessment

Check Diagnosis:

- ☐ ADHD 314.00
- ☐ Anxiety 300.00
- ☐ Arthritis 714.0
- ☐ Bulimia or Binge Eating 307.51
- ☐ Depression NOS 311.0
- ☐ Depression Major 296.3
- ☐ Diabetes II (Non-Insulin) 250.00
- ☐ Diabetes I (Insulin) 250.01
- ☐ Elevated Blood Pressure 796.2
- ☐ Gall Bladder Disease 575.1
- ☐ High Cholesterol 272.0
- ☐ High Triglycerides 272.1
- ☐ Hypertension 401.9
- ☐ Hypoglycemia 296.90
- ☐ Hypothyroidism 244.9
- ☐ Insomnia 307.42
- ☐ Metabolic Syndrome 277.7
- ☐ Obesity 278.0
- ☐ PCOS 256.4
- ☐ Reflux/GERD 530.81
- ☐ Sleep Apnea 780.51
- ☐ Prior Bariatric Surgery
- ☐ Unable to Exercise
- ☐ Back &/or knee problems
- ☐ Other ____

Height: __________ Current Body Weight: _________ Highest Weight: ______ Usual Wt.______ Most Wt. Lost _______

How long have you been at your *current* weight? _____________ Do you currently *binge* on food? ☐ Yes ☐ No

Have you binged on food in the *past?* When? __________________ Do you *currently* purge/vomit? ☐ Yes ☐ No

Check any of the following you've used in an attempt to control your weight: Indicate past or present.

- ☐ Atkins or High Protein
- ☐ Bingeing
- ☐ Diet & Exercise
- ☐ Diet Pills
- ☐ Diuretics
- ☐ Food Restriction
- ☐ Hypnotherapy
- ☐ Jenny Craig
- ☐ Laxatives
- ☐ Liquid Diet
- ☐ Physician Supervised
- ☐ Restricted Calorie
- ☐ Vomiting/Purging
- ☐ Weight Watchers

What other diets have you been on? ____

What time of day/eve is most difficult for stress or emotional eating? ____________________________

What and how much do you eat then? ____

Do you consider yourself a compulsive, emotional, stress or an addictive eater? ____________________

What is your rate of eating? ☐ Slow ☐ Moderate ☐ Fast ☐ Inhale

How many times per week do you eat when you're NOT hungry? ____________________________

Check if you experience these symptoms: ☐ Gas ☐ Bloating ☐ Constipation ☐ Diarrhea ☐ Heartburn

At what age did you start your first diet? _____________ What? ____________________________

Who recommended this?_______________ How did you do? ____________________________

Most Weight Lost on a Diet? ________________lbs. What diet are you currently on? ____________________

What are the reasons you go OFF of a diet? ____

What food allergies do you have? ____

Diet Intake *Please describe what and how much you NOW eat & drink in a typical 24-hour day: Be SPECIFIC!*

Breakfast ____

Snack ____

Lunch ____

Snack ____

Dinner ____

Snack ____

How much fluid (in ounces) do you drink daily? _______Water _______ Soft drinks (sugar? Sugar-free?)

______Alcoholic Beverages _____Coffee/Tea ________ Juices ________Protein Shakes _____ What Else?

What vitamins, minerals and herbal supplements, and amounts, do you now take? Circle: MultiVitamin Fish Oil _

____

P.S. For more tips, products and services to help you, please go to www.EatUpTheGoodLife.com Receive 3 Free Gifts!

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Name: ______________________________ Nutrition Assessment Form

What do you consider a GOOD DAY of eating? ______________________________

____

What do you consider a BAD DAY of eating? ______________________________

____

How many meals do you eat out during the week? ______________________________

How many meals and snacks do you eat during a 24-hour period? ______________________________

Name your favorite foods and snacks: ______________________________

What are your three favorite restaurants? ______________________________

What kind of exercise do you now do ______________, how long?__________, how often? __________

Body Image

On a scale of 0 (low) to 10 (high), how do you currently feel about your **body** (size, shape, weight, etc.): __________

What would you most like to change about your *body*? ______________________________

What do you *like best* about your body? ______________________________

What messages did you receive about your **body** as a child? ______________________________

____

What messages did you receive about **eating** as a child? ______________________________

____

After Surgery:

Describe how your life will *change* after your surgery: ______________________________

____

____

What foods do you think you'll have to give up that you are currently eating? ______________________________

____

Please describe how you will ***feel*** after you lose your weight? ______________________________

____

What is your understanding of your diet *after* surgery? ______________________________

____

Are you willing to *exercise* after surgery? ______________________________

What questions do you have about what you can and cannot eat or drink after your surgery? ______________

____

Who will plan and cook meals at home? ______________________________

What family and friends support you in this surgery? ______________________________

Who told you about the diet before and after surgery so far?

□ Friend □ Family Member □ Dietitian □ Doctor □ Nurse □ Other

Check interest in □ Stress Management □ Emotional Eating □ Binge Eating □ Meal Planning □ Weight Mgmt for Life □ What Else?

Thank you! We really appreciate your input. ______________________________

Please Complete, Sign, and Fax to: Alice Baland, **Fax: 214-291-5354**, Phone: 214-335-5556. **Thank You!**

P.S. For more tips, products and services to help you, please go to www.EatUpTheGoodLife.com Receive 3 Free Gifts!

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