



Thank you for choosing MNGI Digestive Health. You are scheduled for the following service(s):

### **Registered Dietitian**

#### **Bring to your appointment:-**

- **Dietitian – New Patient Form:** Please bring the completed form with you to your appointment.
- **3-Day Food Journal:** Please complete the journal for all 3 days and bring pages 10-12 with you to your appointment.
- **Insurance Card / Photo ID**

#### **Additional items:-**

- **Referral:** If your insurance plan(s) require(s) a referral, *you are responsible for obtaining this referral from your primary care provider or clinic prior to your appointment.*
- **Cancel or Reschedule your appointment:** If you must cancel or reschedule your appointment, please call 612-871-1145 as soon as possible. *If you fail to cancel your appointment, your account may be assessed a \$50 fee.*

#### **Before your consultation:**

Please complete the enclosed **Dietitian– New Patient Form** and **3-Day Food Journal** and bring both forms with you on the day of your appointment.

- Bring a photo ID as well as up-to-date insurance information, such as your insurance card and any referral forms that might be required by your insurance company.
- Co-pays are required on the day of your appointment.

# MNGI Financial Policy

## **Policy Overview**

Payment in full is expected upon receipt of a statement from Minnesota Gastroenterology, P.A. (MNGI) and its Ambulatory Surgical Centers (ASCs). If unable to pay the balance in full, the patient is responsible for contacting MNGI's Business Office to establish payment plan arrangements and to discuss other financial assistance options. Failure to pay a bill and/or comply with any arrangements that have been established may result in the forwarding of the account to a collection agency. Once an account has multiple unpaid balances and/or has been sent to a collection agency, the patient will be unable to schedule future appointments at MNGI and its ASCs until the full balance has been paid.

## **Insurance and Billing Process**

It is your responsibility to confirm your insurance benefits with your insurance plan(s) prior to your clinic visit or procedure. If your insurance plan(s) require(s) a co-payment for your appointment, the co-payment is due at the time of your appointment. To ensure accurate billing, you will be asked to provide current insurance information and photo identification each time you check in for an appointment at one of our offices. Failure to present your current card(s) will release MNGI from any responsibility for incorrect or untimely filing of contracted claims.

*Please alert our reception staff of any changes in insurance or personal information.*

## **Pre-Authorizations and Pre-Certifications**

If your insurance plan(s) require(s) pre-authorization or pre-certification, *you are responsible for calling our Business Office at (612) 871-1145, option 5 prior to your appointment.* Our staff can assist you in obtaining approval for your visit or procedure.

## **Referrals**

If your insurance plan(s) require(s) a referral, *you are responsible for obtaining this referral from your primary care provider or clinic prior to your appointment.*

## **Claims Submission**

If you have provided us with insurance information, we will submit claims to your insurance plan(s) and will assist you in any way we reasonably can to facilitate getting your claims paid. However, your insurance plan(s) may need you to supply certain information directly and it is your responsibility to comply with this request.

## **Billing**

Once your insurance claims have been processed by your insurance plan(s), a statement will be sent to you for any deductible, co-insurance, co-payment or other remaining balance not paid by your insurance plan(s). If you are scheduled for a procedure, you will receive more than one bill. One statement (from MNGI) will represent the physician fees for the appointment; a second, separate statement (from the hospital or ASC where the procedure was performed) will represent the facility fees. You could also receive separate bills from the pathologist (Hospital Pathology Associates) if a biopsy of a polyp or tissue sample was needed and/or a bill from the laboratory (LabCorp or Prometheus) if blood work was done. If Monitored Anesthesia Care (MAC) sedation (Propofol) is administered by an anesthesiologist during your procedure, there will be additional charges billed by Northwest Anesthesia, PA.

## **Payment**

Payment in full is due upon receipt of your statement. We accept payment by credit card (Visa, MasterCard and Discover), personal check or money order. Electronic payments may be made online at [www.mngi.com](http://www.mngi.com). If you are unable to pay your balance in full, it is your responsibility to contact our Business Office to establish a mutually agreeable, interest-free payment plan as soon as possible and to discuss other financial resources which may be available.

## **Financial Assistance**

Providing premier gastrointestinal care is important to us, regardless of one's financial status. MNGI has assistance options available to accommodate a variety of financial situations. If your income is not sufficient to cover your health care costs and you have been unable to establish a mutually agreeable payment plan with our Business Office, you may be eligible for a discount through the MNGI Financial Assistance Program. Please contact our Business Office at (612) 871-1145, option 5 for information regarding the MNGI Financial Assistance Program, discounts for patients who are uninsured, and external financial assistance programs that may be available.

*Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area and the services provided.*

*Thank you for choosing MNGI and understanding and complying with our financial policy. If you have any questions or concerns regarding this policy, please contact our Business Office at (612) 871-1145, option 5.*

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## Dietitian Appointment – New Patient Form

To provide you with the best individualized nutrition care possible, please complete the following questionnaire. **Bring the completed form to your Dietitian visit.**

### PERSONAL INFORMATION

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

### HEALTH INFORMATION

Height: \_\_\_\_\_ Current weight: \_\_\_\_\_ Usual weight: \_\_\_\_\_

Has your weight changed in the past year?  yes  no

If yes, please list: \_\_\_\_\_ pounds  lost  gained Was this intentional?  yes  no

Do you exercise?  yes  no If yes, what type and how often? \_\_\_\_\_

Are there any medical reasons you cannot or should not exercise?  yes  no

If yes, please list: \_\_\_\_\_

Please rate your current stress level  High  Moderate  Low  None

What adds most to your stress?  Family  Money  Health  Work  Other: \_\_\_\_\_

### NUTRITION INFORMATION

Have you met with a Registered Dietitian in the past?  yes  no

If yes, when/where? \_\_\_\_\_

Do you follow a special diet or eating style?  yes  no

If yes, please describe: \_\_\_\_\_

Please list any strong overall food preferences:  
\_\_\_\_\_

Who does your grocery shopping?  myself  other: \_\_\_\_\_

Who prepares your meals?  myself  other: \_\_\_\_\_

How many meals do you typically eat each day? \_\_\_\_\_

Do you ever skip meals?  yes  no If yes, when/why? \_\_\_\_\_

How many meals per week do you typically eat away from home, and where? (for example: at your workplace, restaurant, social event, etc.): \_\_\_\_\_







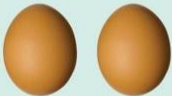





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# Completing your 3-Day Food Journal

As part of your Dietitian visit, we ask that you keep a record of everything you eat and drink for 3 days. Having an accurate record of your intake and eating habits will assist the Dietitian in making specific dietary recommendations for you. A sample journal has been provided for you on page 9. **The journal may be completed at any time as long as it is prior to your Dietitian visit. Please bring pages 10-12 with you to your appointment.**

To complete your food journal, please follow the guidelines below.

- Select days that you will be making **typical** food choices and try *not* to change your eating habits. Holidays and special days may not represent usual eating behaviors.
- **Be honest.** The purpose of this journal is to help you and the Dietitian develop an awareness of your eating habits so that nutrition goals can be individualized.
- Try to include 2 weekdays (Monday-Friday) and 1 weekend day (Saturday/Sunday) for a **total of 3 days** (they do not have to be consecutive). If you are unable to record all 3 days, please do as many days as possible.
- Carry the food journal with you during the day so that items can be recorded *immediately* after they are eaten. Make sure to record the time an item/meal/snack was consumed.
- Record **EVERYTHING** you eat and drink. Please be as specific as possible.
  - List the type of food you ate including all condiments and extras (sauces, gravy, butter, ketchup, mayo, etc.)
  - Describe combination foods, such as what toppings came on the pizza or what was included in the sandwich.
  - Mention how the food was prepared (grilled, baked, fried, steamed, roasted, etc.)
  - List a brand name or restaurant name when possible.
- Include portion sizes for all items, estimating to the best of your ability. For help, please refer to the serving size guide provided on the next page.
- **Don't stress!** If you are not able to complete the food journal, still come to your appointment with the Dietitian.

Object	Hand Symbol	Equivalent	Foods
		<b>Fist</b> 1 Cup (baseball)	Rice, Pasta Fruit Veggies
		<b>Palm</b> 1/2 cup (tennis ball)	Medium Fruit, Ice Cream
		<b>Palm</b> 3 ounces (deck of cards)	Meat Fish Poultry
		<b>Handful</b> 1 ounce (1 large egg)	Nuts Raisins
		<b>2 Handfuls</b> 1 ounce (2 large eggs)	Chips Popcorn Pretzels
		<b>Thumb</b> 1 ounce (ping pong ball)	Peanut Butter Hard Cheese
		<b>Thumb Tip</b> 1 teaspoon (marble)	Cooking Oil Mayonnaise, Butter Sugar



## Sample Food Journal

Date: 12/1/2013

CIRCLE ONE: Weekday Weekend

<b>Breakfast</b>		Time of day: <u>8:00</u> <u>am</u> /pm
<b>Food/Beverage items</b>	<b>Amount/Serving size</b>	
Scrambled eggs with salt and pepper	2 eggs	
Whole wheat toast with margarine	1 slice/1 tablespoon	
Coffee with non-dairy creamer	1 cup (8 oz)/ 2 tablespoons	
Minute Maid® Orange Juice	½ cup (4 oz)	
<b>Lunch</b>		Time of day: <u>12:30</u> am/ <u>pm</u>
<b>Food/Beverage items</b>	<b>Amount/Serving size</b>	
Subway® sandwich: Italian bread, turkey, American cheese, lettuce, tomato, pickles, and mayonnaise.	6 inch sub	
Baked potato chips (plain)	1 small bag	
Diet coke	16 oz	
<b>Dinner</b>		Time of day: <u>6:00</u> am/ <u>pm</u>
<b>Food/Beverage items</b>	<b>Amount/Serving size</b>	
Grilled chicken breast	3 oz (deck of cards)	
Baked potato (with skin) topped with sour cream	1 medium/2 tablespoons	
Lettuce salad – mixed greens with carrots and red cabbage (Dole® brand), tomato, cucumber	2 cups	
Light ranch dressing (Kraft)	2 tablespoons	
<b>Snacks</b>		
<b>Time of day</b>	<b>Food/Beverage items</b>	<b>Amount/Serving size</b>
<u>10:00</u> <u>am</u> /pm	Yoplait® lite strawberry yogurt	6 oz
<u>4:00</u> am/ <u>pm</u>	Apple	1 small
<u>9:00</u> am/ <u>pm</u>	Ben & Jerry's Vanilla ice cream with fresh raspberries	½ cup 1 handful (1 oz)
Estimated Daily Water Intake: <u>64</u> <u>ounces/cups</u>		



## Food Journal Day 1

Date: \_\_\_\_\_

CIRCLE ONE:    **Weekday**    **Weekend**

<b>Breakfast</b>		<b>Time of day:</b> _____ <b>am/pm</b>
Food/Beverage items		Amount/Serving size
<b>Lunch</b>		<b>Time of day:</b> _____ <b>am/pm</b>
Food/Beverage items		Amount/Serving size
<b>Dinner</b>		<b>Time of day:</b> _____ <b>am/pm</b>
Food/Beverage items		Amount/Serving size
<b>Snacks</b>		
Time of day	Food/Beverage items	Amount/Serving size
_____ am/pm		
_____ am/pm		
_____ am/pm		
<b>Estimated Daily Water Intake:</b> _____ <b>ounces/cups</b>		

Was this a typical day's intake?    yes    no

Comments: \_\_\_\_\_

Patient name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_



## Food Journal Day 2

Date: \_\_\_\_\_

CIRCLE ONE:    **Weekday**    **Weekend**

<b>Breakfast</b>		Time of day: _____ am/pm
Food/Beverage items	Amount/Serving size	
<b>Lunch</b>		Time of day: _____ am/pm
Food/Beverage items	Amount/Serving size	
<b>Dinner</b>		Time of day: _____ am/pm
Food/Beverage items	Amount/Serving size	
<b>Snacks</b>		
Time of day	Food/Beverage items	Amount/Serving size
_____ am/pm		
_____ am/pm		
_____ am/pm		
<b>Estimated Daily Water Intake:</b> _____ ounces/cups		

Was this a typical day's intake?    yes    no

Comments: \_\_\_\_\_

Patient name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_



## Food Journal Day 3

Date: \_\_\_\_\_

CIRCLE ONE:    **Weekday**    **Weekend**

<b>Breakfast</b>		<b>Time of day:</b> _____ <b>am/pm</b>
Food/Beverage items	Amount/Serving size	
<b>Lunch</b>		<b>Time of day:</b> _____ <b>am/pm</b>
Food/Beverage items	Amount/Serving size	
<b>Dinner</b>		<b>Time of day:</b> _____ <b>am/pm</b>
Food/Beverage items	Amount/Serving size	
<b>Snacks</b>		
Time of day	Food/Beverage items	Amount/Serving size
_____ am/pm		
_____ am/pm		
_____ am/pm		
<b>Estimated Daily Water Intake:</b> _____ <b>ounces/cups</b>		

Was this a typical day's intake?     yes     no

Comments: \_\_\_\_\_

Patient name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_