Nutrition Registration Information (Please print)

Last name _____ First Name _____ Middle initial _____

Street address _____ City _____ ST_____ ZIP _____

Mailing address _____City_____ ST _____ZIP_____

Email address _____

Phone (h) _____ (w)_____ (c)_____

What is the best way to contact you? _____

Birth date _____Age _____ Gender M / F

Primary Physician_____ Phone _____

Clinic name and address _____

Employer _____Occupation _____

Primary Insurance

Policy holder Name _____Policy holder SS# _____Policy holder Birthdate _____

Your relationship to policyholder _____Policy holder Employer_____

Secondary Insurance

Policy holder Name _____Policy holder SS# _____Policy holder Birthdate _____

Your relationship to policyholder _____Policy holder Employer_____

I hereby,

1. Certify that I have read the HIPAA privacy notice and received a copy (if requested);
2. Authorize insurance payments to be sent to the dietitian, if applicable;
3. Certify that I am financially responsible for all services rendered to me and/or members of my family if my insurance does not reimburse for dietitian services;
4. Certify that I have read and agree to the patient policies and received a copy, if requested;
5. Certify that I am responsible for any late fees if my copay is not paid at the time of service, my balance is not paid within 30 days and/or collection fees of 25% if my balance is not paid in 90 days.

Patient/Guardian (Please Print)_____

Patient/Guardian Signature _____ Date _____

All accounts with outstanding balances will be assigned for collection in 90 days unless other arrangements have been made.

48 HOUR CANCELLATION OF APPOINTMENTS REQUIRED TO AVOID CHARGE