Nutrition Factory Patient Registration Form

Provider: Rhys Wyman, RD, LDN or Shelley Woolsey, RD, LDN or
Hillary Mamis, RD, LDN or June Skuza, RD,LDN

_____New Client _____Change of Client Info - Effective Date:_____

Personal Information:

Name: _____
Address: _____
City, State, Zip: _____
Home Phone: _____
Work or Cell Phone: (circle one) _____
Date of Birth: _____
Gender/Sex: _____
Marital Status: _____
E-Mail Address: _____

Health Insurance Information:

Insurance Company: _____
Identification Number: _____
Subscriber Name: _____
Subscriber DOB: _____
Subscriber Employer: _____
Relationship to Patient: _____
Secondary Insurance Co.: _____

Authorizations: I hereby direct my insurance carrier to make payments directly to the Provider for health insurance benefits otherwise payable to me, but not to exceed the Provider's regular charges of $250.00 for initial visit or $200.00 for follow up visit, with an additional $62.50 for each quarter-hour unit over 60 minutes for an initial visit, and $50.00 for each quarter hour over 50 minutes for a follow-up visit. I understand that I am financially responsible for charges not covered by this authorization (including insurance co-payments, co-insurances and deductibles that are due at the time of service). This assignment of benefits shall be valid for the duration of my treatment.

I also hereby authorize the Provider and the office billing staff or agency to release to my insurance company any billing and medical information necessary to process claims for services rendered to me by the Provider. This authorization is limited to the release of only that information necessary to substantiate and process health insurance claims and excludes such confidential information, which by law may only be released by specific consent.

I also consent to treatment for nutritional counseling for myself or my dependent listed above.

Signature of Patient/Guardian:_____Date:_____

For Office Use Only:

Dx-1_____Dx-2_____Referral #:_____# of visits:_____