Patient Registration Form

Patient's Name: _____ **Date:** _____

Mailing Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Primary Phone Number: _____ **Second Number:** _____

E-mail address (optional): _____

Date of Birth: _____

Marital Status: ___Married ___ Single ___Widowed **Gender**: ___Male ___Female

Guardian's Name (if patient is younger than 18 years old): _____

FOR OFFICE USE ONLY

DOS	Units	*Fee*	*Ins Type*	Ins Filed	Procedure	Codes	Billed / paid	Recorded

INSURANCE ID:_____

Account Notes:

Follow-up appointments:

5601 NW 72nd Street, Suite 232
Oklahoma City, OK 73132
(405) 603-1941 (office)

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided the Nutrition Specialists, PC Notice of Privacy Practices ("Notice"):

• It tells me how Nutrition Specialists, PC will use my health information for the purposes of my treatment, payment for my treatment, and Nutrition Specialists, PC's health care operations.

• The Notice also explains in more detail how Nutrition Specialists, PC may use and share my health information for other than treatment, payment, and health care operations.

• Nutrition Specialists, PC will also use and share my health information as required/permitted by law.

Print Patient's Legal Name: _____

Signature _____
(patient on legal authorized representative)

Date: _____

Relationship of authorized representative to patient _____

Nutrition Specialists, PC
"Connecting Food To Health"

5601 NW 72nd Street, Suite 232
Oklahoma City, OK 73132
(405) 603-1941

CONSENT FOR TREATMENT

The following information is to be completed by the patient or the patient's legally authorized representative/parent:

I consent to medical treatment for myself or for the patient for whom I am the parent or Legally Authorized Representative. I understand that Nutrition Specialists, PC will share patient health information according to federal and state law for treatment, payment, and operations.

I understand that the patient is responsible for all charges incurred, regardless of the patient's insurance status. The patient agrees to pay for services as the patient incurs the charges. I authorized Nutrition Specialists, PC to file insurance claims, including Medicare, on my behalf and I authorize the insurance provider to pay Nutrition Specialists, PC for services rendered.

____ I authorize Nutrition Specialists, PC to leave messages on my phone or e-mail address.

Signature of Patient / Legally Authorized Representative: _____ Date: _____

Relationship of Legally Authorized Representative to Patient: _____