Nutrition Specialists, PC
"Connecting Food To Health"

Patient Registration Form

Patient's Name: _____ Date: _____

Date of Birth: _____

Mailing Address: _____

Primary Phone: _____ Cell Phone: _____

Email Address: _____

Marital Status: _____

Occupation: _____ Hours Worked: _____

Referring Physician: _____

Other Physicians: _____

_____

Guardians Name (if patient is younger than 18 year old) _____

Reason for visit Today: _____

_____

_____

Insurance Company: _____ ID # _____

Social Security # _____

Please supply insurance card and ID for copies

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5601 NW 72nd Street, Suite 200
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 _____

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CONSENT FOR TREATMENT and PAYMENT POLICIES

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 agree that Nutrition Specialists, PC can have correspondence, request records, and send updates/notes with my doctors listed on registration form.

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. Overdue balances greater than 60 days are subject to be turned to a collection agency.

Visit Fees: Nutrition Specialist fees will be billed according to the insurance payment schedule. In event of self-pay it will match the insurance discounted rate. Medical Nutrition Therapy will be charged at $50/15-minute unit.

Cancellation Policy: Nutrition Specialist, PC requires 24-hour notice of any change or cancellation of an appointment. Failure to give 24 hour notice will result in a $50 charge. This will be billed to the client.

_____ I authorize Nutrition Specialists, PC to leave messages and appointment reminders on my phone or e-mail address.

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

Relationship of Legally Authorized Representative to Patient: _____