CLIENT REGISTRATION

Date: _____

Name: _____ DOB: _____
Address: _____
City: _____ State: _____ Zip: _____
SS#_____

How did you hear about us? _____
Goal for today's session: _____
_____
Please list all current health concerns: _____
_____
Please list any/all previous health concerns (within last 10 years): _____
_____

HIPAA Patient Communication Form

As a patient in our practice, from time to time we may need to communicate with you when you are not in the office. To preserve your privacy, we would like for you to indicate your preferred method of communication for medical information to you. This includes appointment reminders.

Without specific permission we will not release any of your medical/nutrition information to another person. In some cases you may wish for another person to have access to your medical information. Please identify those individual(s) and their relationship to you (i.e. spouse, parent, son, daughter, etc)

NAME	**RELATIONSHIP**
_____	_____
_____	_____
_____	_____

In the event that no one is available to answer your phone, we need permission to leave certain types of information on your answering machine/voicemail. Please indicate your preference by checking one of the spaces below:

( ) Do not leave any medical information on my answering machine or voice mail.
In this event you will only be asked for a return call to receive further information.

( ) I give ANW,LLC personnel permission to leave medical information pertaining to my care on my voice mail at the number(s) listed below:

CONTACT INFO
(Please check the preferred method of contact)

(__) Home Phone _____
(__) Work Phone _____
(__) Cell Phone _____
(__) Email _____

I assume responsibility to inform Advantage Nutrition & Wellness, LLC of changes in my phone number (s) or my preference for information release. I also acknowledge that I have received and/or read a copy of Advantage Nutrition & Wellness's privacy practices.

NAME: _____

SIGNATURE: _____ **DATE:** _____

Name: _____ DOB: _____

PAYMENT & FINANCIAL INFORMATION

Who is financially responsible for this account?

Name: _____ DOB:_____
Relation: _____ SS#: _____
Address: _____
Phone: _____

By my signature below I acknowledge:

- All payment, including co-payment, is due at the time services are rendered.
- We accept cash, check, MasterCard, Visa, AMEX, or Discover for acceptable payment.
- A **$ 30.00 fee** is applied for all appointments that are not cancelled within 24 hours of your scheduled date/time of session. **Initials:** _____
- I will pay in full any and all outstanding balances and/or insurance claim which are denied within 30 days of receipt of invoice.
- I will have a late charge of 10% added to my balance if unpaid after 30 days.
- Any balance reaching more than 60 days past due will be sent through our collection process.
- Should my balance be sent for collection, I acknowledge that I will be responsible for all collection fees, as well as any legal fees, that ANW incurs in order to collect my balance.
- There is a **$ 30.00 fee** for a returned check**. Initials:** _____
- All nutrition packages are non-refundable but may be transferable to other in-house services. All packages expire 1 year after date of purchase.

SIGNATURE: _____

DATE: _____

(Financial Information Review)

I have reviewed the above information and agree in full to its content.

Signature: _____ **Date:**_____

_____ **Date:**_____

_____ **Date:**_____

Name: _____ DOB: _____

RELEASE OF MEDICAL INFORMATION

For any / all signed releases on this document, I fully understand that each releases of information must be terminated in writing. _____ initial

Primary Physician: _____
Practice: _____
Address: _____
Phone: _____ Fax: _____
I authorize the release of verbal and/or written information between Advantage Nutrition & Wellness, LLC and the above named physician/medical group: _____ Date: _____
Signature

Secondary Physician / Specialist: _____
Practice: _____
Address: _____
Phone: _____ Fax: _____
I authorize the release of verbal and/or written information between Advantage Nutrition & Wellness, LLC and the above named physician/medical group: _____ Date: _____
Signature

Secondary Physician / Specialist: _____
Practice: _____
Address: _____
Phone: _____ Fax: _____
I authorize the release of verbal and/or written information between Advantage Nutrition & Wellness, LLC and the above named physician/medical group: _____ Date: _____
Signature

Therapist / Specialist or Other: _____
Practice: _____
Address: _____
Phone: _____ Fax: _____
I authorize the release of verbal and/or written information between Advantage Nutrition & Wellness, LLC and the above named physician/medical group: _____ Date: _____
Signature

Therapist / Specialist or Other: _____
Practice: _____
Address: _____
Phone: _____ Fax: _____
I authorize the release of verbal and/or written information between Advantage Nutrition & Wellness, LLC and the above named physician/medical group: _____ Date: _____
Signature