



CLASS REGISTRATION FORM

Date: _____ Class: _____

Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____

Email: _____ SS#: _____

Do you wish to receive e-news updates? Y N

Employer: _____

Address: _____

Phone: _____ Fax: _____

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

Primary Insurance: _____

Name of Insured: _____ DOB: _____

Relationship: _____

Address: _____

Phone#: _____

ID# _____ Group#: _____

Policy#: _____

Assignment of Insurance Benefits

I, the undersigned, have insurance coverage with _____ and assign directly to **ADVANTAGE NUTRITION & WELLNESS, LLC** all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize **ADVANTAGE NUTRITION & WELLNESS, LLC** to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insured/Guardian

Date

ADVANTAGE NUTRITION & WELLNESS, LLC
HIPAA Patient Communication and Release Form

As a client in our practice, we may need to communicate with you outside of the office setting. To preserve your privacy, we would like for you to indicate your preferred method for information communication. Without specific permission we will not release any of your medical and/or nutrition information to another person. In some cases you may wish for another person to have access to your information. Please identify those individual(s) and their relationship to you (i.e. spouse, parent, etc...)

NAME(S)

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:

() Please do not leave any class pertinent information on my answering machine/voice mail when you call the number(s) listed below. In this event you will only be asked for a return call to receive further information.

() I give Advantage Nutrition & Wellness personnel permission to leave any type of pertinent information regarding my class participation on my answering machine/voice mail at the number(s) listed below, which includes class session reminders:

PHONE NUMBER

Home: _____ **Work:** _____ **Cell:** _____

For class participation we require at least one contact provided in the case of an emergency.

EMERGENCY CONTACT:

Name: _____ **Phone:** _____

With my signature below I acknowledge that I assume responsibility to inform Advantage Nutrition & Wellness, LLC of changes in my phone number(s) and/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.

PARTICIPATION WAIVER

My signature below acknowledges that I am assuming all risk for my participation in this class. I understand that this class may require some physical movement and/or physical relaxation techniques. It is my responsibility to inform the instructor of any medical issues and/or other limitations that I may have which may restrict my participation in this class.

PRINT NAME: _____

SIGNATURE: _____ **DATE:** _____