CLIENT REGISTRATION

Date: ________________

Name: ____ DOB: ________________
Address: ____
City: __________________________________ State: __________ Zip: __________________
Home Phone: ___________________________ Email: ____________________________________
SS#__________________________________ Do you wish to receive our e-news announcements? Y N

How did you hear about us?

- ☐ Advantage Nutrition Mailer
- ☐ Doctor (please specify)________________
- ☐ E-Mail
- ☐ E-News
- ☐ Friend/Relative
- ☐ Work
- ☐ In Office Promotion
- ☐ Insurance Company
- ☐ Internet
- ☐ Natural Awakening
- ☐ Market Place
- ☐ Other (please specify)____________________

Please list all current health concerns: ____
____

Please list any/all previous health concerns (within last 10 years): _____________________________
____

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

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

(Yearly Information Review)
The above information remains an accurate representation of my demographic information. I remain aware that I am responsible to provide ANW with changes to this infromation, when applicable.
Signature: ____ **Date:** ______________

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.
- A **$ 30.00 fee** is applied for all appointments that are not cancelled within 24 business hours of your scheduled date/time of session. **Initials:** ___________
- Any and all outstanding balances and/or insurance claim denials are payable within 30 days 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.
- If your balance is sent for collection, you acknowledge that you will be responsible for all collection fees, as well as any legal fees that our office incurs in order to collect the outstanding delinquent balance.
- There is a **$ 25.00 fee** for a returned check**. Initials:** ___________
- All nutrition packages are non-refundable but may be transferable to other in-house services or products. All packages expire 1 year after date of purchase.

SIGNATURE: ____
DATE: _________________

(Yearly Information Review) The above information remains an accurate representation of my financial information. I am aware of my responsbility to provide ANW with any changes in writing when appropriate.

Signature: ____ **Date:** ______________
____ **Date:** ______________

HIPAA Patient Communication Form

NAME: ______________________________________ **DOB**: _______________

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 for us to communicate medical information to you, and to others involved in your care, if needed. Examples of medical information include appointment reminders and nutrition plan information.

Without specific permission we will not release any of your medical/nutrition information to another person. In some cases you may wish for another persona 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 Advantage Nutrition & Wellness personnel permission to leave medical Information pertaining to me on my answering machine or voice mail at the number(s) listed below:

PHONE NUMBER **Home:** ____________________________
Work: ____________________________
Cell: ______________________________

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:** ________________