**Patient Registration Form**

*Please Type or Print Clearly:*

|  |  |
| --- | --- |
| Name of Patient: | Date: |
| Home Address: | |
| City, State: | Zip Code: |
| E-Mail Address: | SSN: |
| Marital Status: | Sex: |
| Date of Birth: | Age: |
| Primary Telephone #: | Cell #: |
| Occupation: | Work #: |
| Employer: | |
| Name of Person Responsible for Bill: | Home-  Work-  Cell- |
| Home Address: | |
| City, State: | Zip Code: |
| E-Mail Address: | |
| Medications (Include prescription and nonprescription drugs, aspirin, laxatives, antacids, oral contraceptives, hormones, vitamins, and herbs): | |

Patient’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_

**Policy Concerning Fees, Payment, and Communication**

Julia Vukicevic, MS, RD provides nutrition counseling as a fee-for-service provider. I agree to the following terms and conditions:

* I understand that if I need to cancel or reschedule an appointment, I must give notice at least 24 hours or one business day (excluding Saturday and Sunday) prior to the scheduled appointment time.
* I understand that I will be charged the full session fee for any cancellation with less than 24 hours’/one business day’s notice.
* Payment for session is due in full at time of service. Julia accepts cash or check only. (All checks may be made out to Anastasia Health LLC).
* There is a $25 fee for any returned checks.

Patient’s Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_

**Credit Card Consent Policy Form**

I, the undersigned, authorize Julia Vukicevic, MS, RD, to keep my credit/debit card on file and to charge it as indicated below.

A charge to my credit/debit card will ONLY be made under the following circumstances:

* Missed appointments and cancellations/rescheduling less than 24 hours before time of scheduled appointment will be charged a full session fee.

I, the undersigned, understand that this form will be valid throughout the duration of my treatment with this office UNLESS I cancel through written notice.

Patient’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cardholder’s Name (if different): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Card Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Exp:\_\_\_\_\_\_\_\_\_\_\_\_\_

3-Digit Security Code:\_\_\_\_\_\_\_\_\_\_

Cardholder’s Billing Address:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Cardholder’s Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Release of Medical Information**

Please provide consent for release of medical information to your other providers. This

will help ensure that you receive the best possible care from everyone on your team.

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, agree to release medical information to Julia Vukicevic, MS, RD. I understand that discretion and judgment will be used in selecting the information to be released and that the receiving person(s) will maintain confidentiality. I voluntarily give consent for the following person(s) to release my prior medical information:

|  |  |  |
| --- | --- | --- |
| Name | Type of Provider | Phone Number |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

I authorize the release of all healthcare information to the following individual/family member:

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Patient Financial Responsibility**

The patient is responsible for ensuring all services and products rendered are paid in full.

**Signatures**

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have read and agreed to the above terms of trade as outlined in this document.

Patient Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provider Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_