LeSash
NUTRITION & HEALTH

1864 Clove Road, Suite D. Staten Island, NY 10304

PATIENT REGISTRATION FORM

Date of Service: ____/____/____ **Please fill in, initial and sign completely**

Patient's Name: _____ **Date of Birth:** ___/___/____ **Age:** _____ **Sex:** _____
Address:

_____

Phone: _____(H) **Mobile:** _____(c) **Email:** _____

Employment Status: ( ) Full time ( ) Part time ( ) Unemployed ( ) Retired. Student: ( ) Yes ( ) No

Is patient's condition related to: Employment, Auto accident, or other Accident: Yes: _____ No: _____

Primary Insurance: _____ Member ID #: _____
Policy Holder's Name: _____ Date of Birth: ___/___/___ Relationship to insured: _____
Referring Physician's Name: _____ Primary Care Physician: _____

Secondary Insurance: _____ Member ID #: _____
Policy Holder's Name: _____ Date of Birth: ___/___/___ Relationship to insured: _____
Referring Physician's Name: _____ Primary Care Physician: _____

Reason (s) For Visit: _____.

Cancellation / No show Policy Appointment: If an appointment is not cancelled at least 24 hours in advance you will be charged a Twenty-five ($25.00) fee; this will not be covered by your insurance. **Scheduled Appointments:** If Client(s) is 15 minutes past their scheduled time, we will have to reschedule the appointment. **Account Balances:** For self-pay clients, we will require that Clients pay account balances to zero prior to further services.

The information above has been reviewed and is correct. Client's / Authorized Person's Initials: _____.

Assignment of Benefits

I hereby authorize that my insurance benefits be paid directly to Jennilyn Jackman Baptiste, RD, CDN / LeSash Nutrition & Health, LLC and acknowledge that I am financially responsible for any unpaid balance. Please remember that payment is your obligation regardless of insurance or other third-party involvement.

Client's / Authorized Person's Signature: _____ **Date:** _____/_____/_____.

Authorization to Treat

I authorize Jennilyn Jackman Baptiste, RD, CDN / LeSash Nutrition & Health, LLC to provide necessary treatment including measurements, individualized meal plans, nutrition education, recommendations and any other as may in her professional judgement to be necessary.

Client's / Authorized Person's Signature: _____ **Date:** _____/_____/_____.

Authorization to Release Health Care Information

I request and authorize Jennilyn Jackman Baptiste, RD, CDN / LeSash Nutrition & Health, LLC to release healthcare information to the referring Physician and any other health professional I am referred to by Ms. Baptiste.

Client's / Authorized Person's Signature: _____ **Date:** _____/_____/_____.