



LeSash

NUTRITION & HEALTH

P.O. Box 320648 Brooklyn, NY 11232 - 0648

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

Method of Payment

Responsible Person's Name: _____ Date of Birth: ___/___/___ Relationship : _____

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. **Scheduled Appointments:** If Client(s) is 15 minutes past their scheduled time, we will have to reschedule the appointment. **Account Balances:** Clients, we will require to pay account balances to zero prior to further services. **The information above has been reviewed and is correct. Client's / Authorized Person's Initials:** _____

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: ___/___/___.