NUTRITION ADVANTAGE, LLC

NAME: _____ **DATE:** _____

DEMOGRAPHIC INFORMATION

TODAY'S DATE: _____

NAME Last: _____ **First:** _____ **MI:** _____

TITLE: ____Mr _____Mrs ____Miss ____Dr ____Other: _____ **GENDER: M** _____**F** _____

DATE OF BIRTH: _____ **SOCIAL SECURITY NUMBER**: _____

ADDRESS: Street/Apt _____**City:** _____ **State:** _____ **Zip Code:**_____

HM PHONE: _____ **WK PHONE:** _____**EMAIL ADDRESS:** _____

WHERE DO YOU PREFER WE LEAVE A MESSAGE? Home: _____ **Work:** _____

MARITAL STATUS: Single: _____ **Married:** _____ **Divorced:** _____ **Separated:** _____ **Widowed:** _____

EDUCATION: (Highest grade completed or degree obtained) _____ **Special certification:** _____

EMPLOYMENT STATUS: Fulltime: _____ **Part-time:** _____ **Retired:** _____ **Unemployed:** _____ **Disabled:** _____

CURRENT EMPLOYER: _____ **OCCUPATION:** _____

CURRENT SCHOOL: _____ **YEAR:** _____ **COURSE OF STUDY:** _____

IF PATIENT IS A DEPENDENT:

Residential Parent Name: _____

Non-Residential Parent Name: _____ **Address:** _____

Phone Number: _____

PERSON TO CONTACT IN AN EMERGENCY:

Name: _____

Home Phone Number : _____ **Work Phone Number:** _____

Address: _____

PRIMARY INSURANCE COVERAGE:

NAME OF PRIMARY INSURANCE COMPANY: _____

STREET ADDRESS _____

CITY:_____ STATE: _____ ZIP:_____

SUBSCRIBER #: _____INSURANCE GROUP # _____

CUSTOMER SERVICE NUMBER: _____

POLICY HOLDER'S NAME: _____

BIRTHDATE OF POLICY HOLDER: _____/_____/_____

SS# OF POLICY HOLDER _____/_____/_____

PATIENT RELATIONSHIP TO INSURED: { } SELF { } SPOUSE { } DEPENDANT

EMPLOYER OF POLICY HOLDER: _____

RESPONSIBILITY FOR PAYMENT

I understand and acknowledge the following terms and conditions for collection and payment of services provided:

I agree to complete necessary paperwork and provide a copy of my insurance card if from a participating insurance plan.

I agree to notify the office at least 24 buisness hours before a scheduled appointment if I cannot keep the appointment if possible. (emergencies excluded) A $25 cancellation fee will be assessed for missed appointments without notification, at the discretion of the office.

For Aetna, Anthem, Medical Mutual, and UnitedHealthCare:
I authorize Nutrition Advantage, llc to bill my health insurance plan for direct payment.

I agree to pay all co-payments and deductibles required by my plan.

I agree to pay for services rendered that are not covered by my plan.

For All Other Health Insurance Plans:
I agree to pay for services at the time they are delivered.

Signature of Client or Parent/Guardian _____
Date _____