Linda S. Caley, MS, RD, CEDRD • Nutrition Counseling
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CLIENT REGISTRATION INFORMATION *(Please Print)*

First Name _____ Middle Initial _____ Last Name _____

Birth date _____ Male/ Female_____ Marital Status_____

Phone (H) _____ (W) _____ Cell_____

E-mail address _____

Street Address_____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____

Who referred you? Physician Health Practitioner Friend/Relative Other

Primary Physician _____ Phone #_____

Your Employer _____ Your Occupation _____

PRIMARY INSURANCE _____ ID# _____ Group# _____

Policy Holder Name _____

Policy Holder Address _____

Policy Holder Birthdate _____ Your Relationship to Policy holder _____

Policy Holder Employer _____

SECONDAY INSURANCE _____ID#_____ Group#_____

Policy Holder Name _____

Policy Holder Address _____

Policy Holder Birthdate _____ Your Relationship to Policy holder _____

Policy Holder Employer_____

I HEREBY:
1) CERTIFY THAT I HAVE RECEIVED AND HAVE READ A COPY OF THE HIPAA PRIVACY NOTICE.
2) AUTHORIZE THE RELEASE OF ANY MEDICAL INFORMATIONNECESSARY TO PROCESS THIS CLAIM FOR PAYMENT.
3) AUTHORIZE INSURANCE PAYMENTS TO BE SENT TO THE DIETITIAN IF APPLICABLE.
4) CERTIFY THAT I AM FINANCIALLY RESPONSIBLE FOR ALL SERVICES RENDERED TO ME AND/OR MEMBERS OF MY FAMILY, IF INSURANCE DOES NOT REIMBURSE THE DIETITIAN.
5) CERTIFY THAT I HAVE RECEIVED AND AGREE TO THE CALEY NUTRITION APPOINTMENT GUIDELINES.

PATIENT/GUARDIAN SIGNATURE_____**DATE**_____
24 HOUR CANCELLATION OF APPOINTMENTS REQUIRED TO AVOID CHARGE