ANASTASIA HEALTH

Patient Registration Form

Please Type or Print Clearly:

Name of Patient:	**Date:**
Home Address:	
City, State:	Zip Code:
E-Mail Address:	
Primary Telephone #:	Cell #:
Marital Status:	Sex:
Date of Birth:	Age:
SSN:	
Occupation:	Work #:
Employer:	

Billing Info:

Name of Person Responsible for Bill (if different from above):	Primary Telephone #:
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:_____

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Policy Concerning Fees, Payment, and Communication

Isabelle Carren-Le Sauter MS, RDN 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 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' notice
- Payment for session is due in full at time of service. Isabelle accepts cash, checks, or credit cards for a $5 convenience fee
- There is a $25 fee for any returned checks.

Patient's Signature:_____ Date:_____

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Credit Card Consent Policy Form

I, the undersigned, authorize Isabelle Carren-Le Sauter MS, RDN 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.
- The full cost of the visit (or a package of visits, if desired) will be charged at time of service (or at time of first visit for packages).

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: _____

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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 Isabelle Carren-Le Sauter, MS, RDN. 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	E-Mail Address

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

Name_____ Relationship_____

Phone _____

Patient Signature:_____Date:_____

Provider Signature:_____Date:_____

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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:_____