

Feed the Soul Nutrition, Inc.

727 Washington Street
Watertown, NY 13601
(315) 783.6810

3 Lyons Place
Ogdensburg, NY 13669

Thank you for selecting our healthcare team to meet your Medical Nutrition Therapy needs! We will strive to provide you with the best possible healthcare. To help us meet all of your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us – we will be happy to help.

Personal Information

Date _____ Date of Birth _____

Soc. Sec. # _____

Name _____

Wishes to be called _____

Male Female Minor Single Married Divorced Widowed Separated

Address _____

City, State, Zip _____

Employer _____ Occupation _____

Referred by _____

Contact Information

Home Phone _____ Pharmacy Name _____

Work Phone _____

Cell Phone _____

Where do you prefer to receive calls? Home Work Cell

Can we leave a message? Yes No

When is the best time to reach you? Time _____ Days _____

Email _____

In the event of an emergency, who should we contact?

Name _____ Relationship _____ Work # _____ Home# _____

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Insurance Information

Primary Insurance

Name of Insured _____
Relationship to patient _____
Insured's date of birth _____
Soc Sec. # _____
Employer _____
Date Employed _____
Occupation _____
Insurance Company _____
Policy # _____
Group # _____
Ins. Co. Address _____

Additional Insurance

Name of Insured _____
Relationship to patient _____
Insured's date of birth _____
Soc Sec. # _____
Employer _____
Date Employed _____
Occupation _____
Insurance Company _____
Policy # _____
Group # _____
Ins. Co. Address _____

Responsible Party

Who is responsible for the account? Please check one and complete as appropriate.

Same as above
 Other: Name _____
Relationship to patient _____
Date of Birth _____ Driver's License # _____
Soc. Sec. # _____
Address _____
City, State, Zip _____
Employer _____
Occupation _____
Work Phone _____ Ext. # _____
Home Phone _____

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Authorization and Release

I authorize the release of any information including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/or other health care practitioners.

I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependent.

Signature of patient or parent if minor

Date

Financial Arrangements

TO OUR PATIENTS

We are required by law to collect any and all co-insurance, co-pays or deductibles that your health insurance carrier imposes upon you. We also require, from you, payment of our fees at time of service for any self-pay accounts. In addition, due to the unique nature of our practice, we require 24 hours notice of cancellation of an appointment. In the event, that you do not provide 24 hours notice of cancellation or you do not show for your appointment, you will be charged \$25. Lastly, any check that is returned to us because of insufficient funds is subject to a \$25 returned check fee.

For your convenience, we offer the following methods of payment.

Please check the option which you prefer.

Payment in full is due at each appointment.

_____ Cash

_____ Personal Check

_____ I wish to discuss the office's payment policy.

Thank you for filling out this form completely. The information you have provided will help us serve your healthcare needs more effectively and efficiently. If you have any questions at anytime, please ask – we are always happy to help.

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