Be Well. Morristown-Pediatric Forms

CLIENT REGISTRATION FORM

DATE:_____

CLIENT FULL NAME:_____

GENDER: Female Male

HOME ADDRESS:_____

City:_____ State:_____ Zip Code:_____

PATIENT CONTACT INFORMATION (if over 18): Home Phone_____

Cell:_____

Email:_____

*Can a confidential message be left on these numbers? Home: Yes No , Work: Yes No , Cell: Yes No

*Can we include your email address provided to our mailing list? Yes No

CLIENT DOB:_____ AGE:_____

CURRENT HEIGHT:_____ CURRENT WEIGHT:_____

PERSON RESPONSIBLE FOR PAYMENT:_____

RELATIONSHIP TO PATIENT_____

HOME ADDRESS: Same as above? YES/NO
If No:_____

PARENT/GUARDIAN PHONE NUMBERS: Home:_____
Work:_____

Cell:_____ Parent/Guardian Email:_____

*Can a confidential message be left on these numbers? Home: Yes No , Work: Yes No , Cell: Yes No

PRIMARY INSURANCE COMPANY NAME_____

ID#_____ GROUP#_____

CLAIM FILING ADDRESS (on back of card typically):

_____

SPECIALIST COPAY AMOUNT_____

INSURED'S NAME:_____ **DOB:**_____

RELATIONSHIP TO CLIENT_____

ADDRESS (if different)_____

Do you have any other Insurance? Yes No (if Yes, list name and ID# on line below)

_____

EMERGENCY CONTACT:_____ **Relation:**_____

Home Phone:_____ **Work Phone:**_____ **Cell Phone:**_____

How did you hear of Be Well?_____

PEDIATRICIAN: _____ **PHONE NUMBER:**_____

City:_____ **State:**_____ **Zip Code:**_____

REASON FOR VISIT: (Please describe)_____

CURRENT MEDICATIONS:_____

VITMAINS MINERALS SUPPLEMENTS: (circle all that apply)

Multivitamin with iron	Vitamin B-12	Fish Oil
Multivitamin without iron	Folic Acid	Probiotics
Iron Supplement	Magnesium	Fluoride
Calcium with Vitamin D	Potassium	Vitamin E
Selenium	Vitamin C	Zinc
Chromium	Vitamin B-Complex	Protein powder or shakes

OTHER SUPPLEMENTS/HERBALS

_____

Be Well. Morristown

Authorization to Obtain and Release Confidential Information for the Purpose of Assessment and Future Treatment

I, _____ (**Client name, Parent or Guardian (if patient under 18)**), hereby authorize Be Well, LLC., to obtain and release information regarding past and current treatment for _____ (**Client name**) to and from the following listed below. This information may include full health history, general and specific information regarding medical and psychological assessment/treatment and progress notes, laboratory test, growth charts, special evaluations/testing, nutrition evaluation and counseling, school performance, social and emotional functioning, special learning problems or capabilities, educational testing, etc.

Please provide the contact information for your <u>current and/or past physician, psychiatrist, nutritionist, treatment center, coach, school/university, personal and family members</u> with who you chose to have Be Well, LLC., communicate with as part of your treatment.

_____	_____
***Name/Title** **Relationship**	***Name/Title** **Relationship**
_____	_____
Address	Address
_____	_____
City Zip code	City Zip Code
_____	_____
Phone Number Fax Number	Phone number Fax Number
_____	_____
Email/Website	Email/Website
_____	_____
***Name/Title** **Relationship**	***Name/Title** **Relationship**
_____	_____
Address	Address
_____	_____
City Zip code	City Zip Code
_____	_____
Phone Number Fax Number	Phone number Fax Number
_____	_____
Email/Website	Email/Website

I understand that my records are confidential and will not be disclosed without my consent unless under legal compulsion or in life threatening situations. I also understand that I may revoke consent at any time, except to the extent that action has been taken in reliance therein.

_____	_____
Client Signature	**Date**
_____	_____
Parent/Guardian signature	**Date**

Be Well. Morristown

Welcome, and thank you for allowing us the opportunity to help you meet your nutritional goals. The following information will provide you with some general information regarding our practice.

Schedule of Fees- Pediatric Nutrition

If your visit is not covered by insurance, Initial assessments are typically 60-90 minutes at a rate of $175.00. Follow-up sessions are typically 30-45 minutes at a rate of $100. Telephone consultations that are five minutes or less are complimentary, for 5-15 minutes a rate of $30.00 will be applied, up to 30 minutes a rate of $75.00 will be applied, beyond 30 minutes the regular fee schedule will apply. Fees are subject to change with a 30-day in office and website notice.

Insurance Reimbursement and Payment

It is the client's responsibility to contact their insurance company prior to the first appointment to obtain information on what diagnoses and conditions will be reimbursed, and what will not be reimbursed. Some insurance companies require prior approval and a physician's referral in order to obtain reimbursement. The client must present proof of medical insurance upon first appointment. Please give notice if there is a change in your medical insurance or if you wish a secondary medical insurance to be billed. In this case, please be prepared to present proof of your new or secondary medical insurance at beginning of your session.

Fees and co-payments may be paid in credit card, or in cash or personal checks made payable to Janet Kopchinski- Be Well Morristown. Payment is due at the beginning of each appointment. Questions about fees and payment should be discussed prior to or at the beginning of your appointment. Fees for phone sessions and missed appointments can be processed by credit card, or should be mailed to: **Be Well Morristown, 16 Bank Street, Morristown NJ 07960**

Any fees incurred for returned checks or any other costs associated with collection of fees will be the responsibility of the client. A 10% late fee will be assessed monthly on any unpaid balance of 30 days or more.

Credit Card Information

I authorize Be Well. Morristown. to charge the credit card below for any unpaid balances for services rendered. Charges will be consistent with the fee structure outlined in the Fees and Payment Policies Agreement above. This authorization will remain in effect until terminated by me in writing.
Card Type: _____Visa ____Mastercard ____American Express _____Discover Card Number:

Card Number: _____

Expiration Date: _____
3-Digit Security Code (on back of card): _____

Card Holder Name and contact information (if different than patient):
First Name: _____

Last Name: _____

Billing address (please include city, state and zip code):_____

_____

Phone Number: _____

Appointments

24-hour cancellation notice is respectfully required. You will be charged for the missed appointment unless notice of cancellation is received 24 hours in advance of the scheduled time. This fee is waived in the case of hospitalization or natural disasters. The fee for missed appointments is due within 7 days or at your next appointment, which ever comes first.

*As a courtesy to our other clients, if you have a contagious illness (cold, flu, etc.), you are encouraged to cancel the appointment and reschedule when you are well again.

If you are late to your appointment, the session will still end at the scheduled time.

Phone sessions are available for clients once a relationship has been established or during a natural disaster or inclement weather. It is the responsibility of the client to initiate the call for a phone session.

Client Acknowledgments: I am aware that the practice of medical nutrition therapy is not an exact science and I acknowledge that no guarantees have been made to me as to the results of nutrition counseling.

I hereby acknowledge that I have read the above and all my questions have been answered to my full satisfaction. I also acknowledge responsibility for this account and assume and guarantee payments of all charges against the account as they accrue.

Client signature:_____ **Date:**_____
Client or Parent/Guardian if client is under age 18

Be Well. Morristown

I, _____ (Client name, Parent or Guardian) have completed the CLIENT REGISTARTION FORM, answering all questions asked, and providing all information required, to the best of my knowledge and ability.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature Date

I, _____ (Client name, Parent or Guardian) have a received a copy of the HIPAA PRIVACY NOTICE, and all questions I have regarding this document have been answered to my satisfaction.

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature Date