



NEW PATIENT REGISTRATION Form 1

Print and Fax To Our Secure Confidential FAX Line (866)293-4500

Or scan and email to: LA@lifefocusnutrition.com

PERSONAL INFORMATION FOR PAYMENT AND REFERRALS

Patient Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Email: _____

Work Phone: _____ Cell Phone: _____

Home Phone: _____ Date of Birth: _____

Name of custodian guardian or parent if for a child: _____

Person Responsible for payment if different than above: _____

Date of Birth: _____ Phone if different than above: _____

Address: _____

City: _____ State: _____ Zip: _____

Please complete the following if you have an Insurance Coverage Plan

Also confirm if the plan includes coverage for the Nutrition Counseling Services

Primary Insurance Holder's Name: _____

Date of Birth: _____

Name of Patient: _____

Name of Insurance Company: _____

Insurance Co. ID# for Patient: _____

Insurance/Medical Information: [Click here \(Insurance Details\)](#)

✓ If your insurance plan requires a referral please obtain this prior to booking your appointment.

✓ Check Your Insurance Coverage Nutrition Counseling by a registered dietitian. Ask, "Do they accept the medical nutrition therapy codes: Initial: 97802 and Follow-up:97803 and Group: 97804? **Yes/ No**

If no, ask what codes are acceptable for nutrition counseling since the codes used by the government lists the above codes. Place here _____

Name Referring Physician or Primary Care Physician: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: () _____ Fax() _____

Names/address of other Healthcare Providers the patient are currently sees:

Click here To Print our MD Referral Form to give to your primary care physician(MD) to get necessary information. ___Check here if you were able to give it to your MD or ___Check here if you wish us to send it.

If you have Insurance, include the name of the physician listed with your insurance carrier.

Please provide any other information to help us get started.

I have read the missed and late appointment policy and read the HIPPA Privacy Notice and Agreement to its terms to release information for treatment and services rendered.

Print Your Name: _____

Signature _____ **DATE** _____ *Thanks and we look forward to assisting you!*