PATIENT REGISTRATION
PLEASE SIGN BOTTOM LINE

Patient's Name: Last: _____ M.I. _____ First _____

Birth Date: _____ Gender: □ Male □ Female SSN: _____

Street/Billing Address: _____

City: _____ State: _____ Zip: _____ - _____

Main Phone: _____ Alternate Phone: _____

Referring Provider: _____ Primary Care Physician: _____

Emergency Contact Name/Relationship: _____

Phone: _____

RESPONSIBLE PARTY / INSURANCE GUARANTOR

Name:
Last_____M.I. _____First _____

Address: _____
Street City State Zip Code

Main Phone: _____ Email: _____

SSN: _____ Date of Birth: _____Relationship to Patient: _____

Main Phone: _____ Alternate Phone: _____

Employer: _____ Telephone: _____

INSURANCE INFORMATION

PRIMARY: Insurance Company & ID #: _____

Subscriber Name/DOB: _____

SECONDARY Insurance Company & ID #: _____

ASSIGNMENT OF BENEFITS AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION

I hereby assign all medical benefits, to include all major benefits to which I am entitled, including Medicare, private insurance, and any other health plan to Sage Nutrition LLC. This assignment will remain in effect until revoked by me in writing. A photocopy of the assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance. Should it become necessary to turn my account over to an outside collection agency, I will be responsible for collection costs, attorney fees, litigation fees, and court costs. I hereby authorize Sage Nutrition LLC and its employees and agents TO RELEASE ALL INFORMATION, reports, and records if necessary for the purposes of treatment, payment and healthcare operations, including a discussion of my medical condition, to the insurance provider, rehabilitation provider, employer, hospitals, and doctors. If I have a liability injury, I understand that I have the option of using my health insurance, if available, or I will be expected to pay for treatment.

Signature: _____ Date:_____

Responsible Party: _____ Date:_____

PRIVACY AND CONSENT

NOTICE OF PRIVACY PRACTICES:

You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you read it in full. Our Notice of Privacy Practices is subject to change. You have a right to request that we restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement. You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

I acknowledge that I have been offered a copy of Sage Nutrition LLC's Notice of Privacy Practice Policy, which describes how my health insurance information may be used or disclosed.

LIMITS OF CONFIDENTIALITY AND CONSENT TO TREAT:

Information obtained during assessments and psychotherapy is confidential and can ordinarily be released only with your written permission. There are some special circumstances that can limit confidentiality including: a) a statement of intent to harm self or others, b) statements indicating harm or abuse of children or vulnerable adults, and c) issuance of a subpoena from a court of law. A report is also provided to the referral source, typically for the purpose of treatment, unless you specifically indicate, in writing, you do not wish this to occur.

I agree and consent to participate in behavioral health care services offered and provided at/by Sage Nutrition LLC. I understand that I am consenting and agreeing only to those services within the scope of the provider's license, certification, and training. If the patient is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of this individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

_____ _____

Print Patient Name Date of Birth

_____ _____

Patient/Responsible Party Signature Date