Client Registration

fueling fitness

Achieving weight, health and performance goals. One step at a time.

Client Name: First	Middle	Last		Home Phone	
Home Address		City		State	Zip Code
Occupation	Marital Status	Date of Birth		Age	Gender
Email Address		Cell Phone			
Employer	Address			Work Phone	
Spouse (or parent) Name					
Spouse (or parent) Employer				Work Phone	
Family Physician	Address			Phone	
Referred By	Address			Phone	

BILLING AND INSURANCE INFORMATION

PRIMARY INSURANCE	Insurance Company Name		ID or Policy Number	Group/Code
	Subscriber's Name		Date Effective	
	Subscriber's Date of Birth	Sex	Home Phone Number	Relationship

Do you have any other Insurance? ❒ **Yes** ❒ **No** **(If yes, please specify)** _____

A message: ❒ **can** ❒ **can not** **be left on my home phone.** **(Please check a box.)**

Marcia Bristow MS RD CD requires your consent to use and disclose your protected health information to carry out treatment, payment and healthcare operations. If you would like a more detailed description of such uses and disclosures please refer to our Notice of Privacy Practices. You have the right to review our Notice of Privacy Practices before signing this Consent. The terms of our Notice of Privacy Practices of Marcia Bristow MS RD CD may change from time to time. You can get a copy of our revised Notice of Privacy Practices by contacting our office at 802-777-9691. We will also post a copy of our current Notice of Privacy Practices in our office.

You have the right to revoke this consent in writing and the revocation will be effective except to the extent Marcia Bristow MS RD CD has acted in reliance on your consent.

I have had an opportunity to discuss with the Registered Dietician and/or with other office personnel, the nature and purpose of medical nutrition therapy. I understand the results are not guaranteed. I give Marcia Bristow MS RD CD permission to send a summary note to my physician or referring doctor of my consultation here.

By signing below, you hereby consent to our use of your protected health information for treatment, payment and health care operations and acknowledge receipt of a copy of this Consent if requested.

Printed Name: _____

Signature: _____ Date: _____