



8119 Shaffer Parkway, Suite #104 • Littleton, CO 80127 • Phone 303.949.1177 • Fax 303.933.8882

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**PATIENT DEMOGRAPHIC INFORMATION**

(THIS INFORMATION IS TO BE UPDATED YEARLY OR WITH ANY INFORMATION CHANGES)

**PATIENT INFORMATION**

Patient Name: \_\_\_\_\_ Patient's Social Security Number: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ GENDER: M F Marital Status: S M D W  
Language Preference if not English: \_\_\_\_\_ Other communication issues? N\_\_ Y\_\_ (what?) \_\_\_\_\_  
Street Address: \_\_\_\_\_ Apt. No.: \_\_\_\_\_  
City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home phone: (\_\_\_\_) \_\_\_\_\_ Work phone: (\_\_\_\_) \_\_\_\_\_  
Cell/Pager number: (\_\_\_\_) \_\_\_\_\_ Email Address: \_\_\_\_\_

**GUARANTOR/PARENT INFORMATION**

Emergency Contact Name: \_\_\_\_\_ Emergency Contact Phone: (\_\_\_\_) \_\_\_\_\_  
Responsible Party Name: \_\_\_\_\_  
(Last) (First) (Middle)  
Relationship to Patient: \_\_\_\_\_ Responsible Party Date of Birth: \_\_\_\_\_  
Guarantor's Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Guarantor's Address: \_\_\_\_\_ Apt. No.: \_\_\_\_\_  
City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Home phone: (\_\_\_\_) \_\_\_\_\_ Cell/Pager number: (\_\_\_\_) \_\_\_\_\_  
Employer's Name: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_  
Employer's Address: \_\_\_\_\_  
City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code: \_\_\_\_\_

**PATIENT'S INSURANCE INFORMATION \*Please provide Insurance Card and Photo ID**

Company's Name: \_\_\_\_\_  
Insurance Address: \_\_\_\_\_  
City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone Number (\_\_\_\_) \_\_\_\_\_  
Name of Policy Holder: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Insurance ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_  
Phone Number for Provider: \_\_\_\_\_ Fax: \_\_\_\_\_

**Secondary Insurance Company's Name:** \_\_\_\_\_

Insurance Address: \_\_\_\_\_  
City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Phone number (\_\_\_\_) \_\_\_\_\_  
Name of Policy Holder: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**PATIENT'S REFERRAL INFORMATION**

Insurance ID Number: \_\_\_\_\_ Group Number: \_\_\_\_\_  
Primary Care Physician \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Referring Physician \_\_\_\_\_ Phone (\_\_\_\_) \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

**Please Read and Sign Both Sides of this Form:**

I hereby authorize my insurance benefits to be paid directly to Christina Scribner. I understand and am responsible for all charges including my added costs incurred due any effort to collect for services rendered. I realize I am responsible to pay for non-covered services and I hereby authorize the release of pertinent medical information to insurance carriers.

Signature of Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

## **IMPORTANT OFFICE POLICIES RELEASE OF MEDICAL INFORMATION**

I authorize Christina Scribner, MS, RD, CSSD and Encompass Nutrition LLC to release the medical records concerning my son/daughter/self to any physician, hospital, or agency involved in the care of the patient listed.

### **ASSIGNMENT OF MEDICAL BENEFITS**

I authorize my insurance carrier to assign all medical benefits, if applicable, to Christina Scribner, MS, RD, CSSD and Encompass Nutrition LLC. I also authorize release of medical information necessary to process all medical insurance claims.

### **PAYMENT POLICY**

The normal rate for appointments is \$104; the initial visit is longer and other visits may be shorter or longer, so are pro-rated. Telephone visits are charged at the normal rate. All medical services provided are directly charged to the patient or responsible party. Payment is expected in full upon receipt of statement or payment arrangements must be made.

### **INSURANCE**

Each insurance company is different and I am unable to know every policy. In most cases, insurance will not be filed for you. Prior to your first visit you may want to consult with your insurance company regarding pre-approval and coverage of nutrition services.

If services are within you insurance contract, I will accept their negotiated rate for the charges billed. However, you will be responsible for any balance deemed patient responsibility/non-payable/non-covered by your insurance and billed accordingly.

Your payment receipt from each visit can be attached to your insurance forms and submitted to your insurance company.

Co-payments are to be collected at the time services are received. I accept cash or checks.

### **CANCELLATION POLICY**

If an appointment needs to be cancelled I must receive notice no later than 4 hours prior to the appointment. I reserve the right to charge \$50.00 for the *first* "no show" appointment, to be collected on or before your next appointment. Subsequent "no shows" will be billed at the regular rate.

### **REFERRAL POLICY**

I understand that it is my responsibility to obtain a referral through my primary care physician's office if required by my insurance company. Failure to do so will result in charges being billed directly to myself.

**I HAVE READ, UNDERSTAND, AND AGREE TO ABIDE BY THE ABOVE RELEASE OF MEDICAL INFORMATION, PAYMENT, AND OTHER OFFICE POLICIES.**

Signature of Responsible Party: \_\_\_\_\_ Date: \_\_\_\_\_

8101 S Shaffer Pkwy, Littleton CO 80127, Ste 102 (across from the Ken Caryl Police Station)

