

**Instructions for completion: Please complete the first box. If the client is a dependent, parents, please complete the second box. You are responsible for the full payment of your account within 60 days of service.**  
**If paying by credit card or using Regence insurance please complete the bottom half.**

**General Information**

Client Name (First, Middle Initial, Last) \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
Mailing Address: \_\_\_\_\_  
Phone Number: \_\_\_\_\_ May I call you here? (Y/N) May I leave you a message here ? (Y/N)  
Email: \_\_\_\_\_  
Marital Status (single, married, divorced) \_\_\_\_\_  
Employment Status (employed, full-time student, part-time student) \_\_\_\_\_  
Emergency contact (name and number) \_\_\_\_\_

**Child and Adolescent Consent for Treatment (if applicable)**

Client Name (please print) \_\_\_\_\_ Date of Birth \_\_\_\_\_  
I certify that I am the (check one) \_\_\_\_ father, \_\_\_\_ mother, \_\_\_\_ legal guardian of the above named child/adolescent and that I do have legal custody of the above named child/adolescent. I, hereby, give my authorization and consent for the above named child/adolescent to receive nutrition counseling from Monica Van Winkle, MS, RD or Emily Edison, MS, RD  
Parent or Legal Guardian Name (please print) \_\_\_\_\_  
Signature \_\_\_\_\_  
Date \_\_\_\_\_

**Payment Methods (cash and check are always welcome):**

**1. Credit Card payments (complete only if you are paying with credit card):**

If I choose my method of payment to be credit card for regular services, Monica can manually enter the information or swipe the card in the appointment.

Credit Card information (required): Credit card type (circle one): Visa Mastercard Discover  
Card number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_  
Expiration date: \_\_\_\_\_ / \_\_\_\_\_ CVC number (3 digit code on back of card): \_\_\_\_\_

If credit card is the primary method of payment I understand a nonrefundable fee will be charged for any cancellation/no show less than 24 hours and for outstanding balances, including claims denied by insurance. Please note that insurance cannot be billed for missed appointments.

Cardholder's signature: \_\_\_\_\_

**2. Insurance: (complete only if you are using Regence insurance for visits)**

**Please have your insurance card with you so a copy can be made for our files.**

Name of Insurance Plan: \_\_\_\_\_  
Name of Insured (First, Middle Initial, Last): \_\_\_\_\_ Date of Birth of Insured: \_\_\_\_\_  
Insured's Employer \_\_\_\_\_ Insured's Gender \_\_\_\_\_  
Is this an individual plan or a plan through the Insured's employer? \_\_\_\_\_  
Address of Insured: \_\_\_\_\_  
Insured ID Number: \_\_\_\_\_ Group ID: \_\_\_\_\_  
Name of Insured's Employer: \_\_\_\_\_  
Phone Number of Insured: \_\_\_\_\_ Co-pays: \_\_\_\_\_

I agree to pay, in full, any balance that is not covered by insurance. Signature: \_\_\_\_\_

\*If you have a secondary insurance plan, please fill out a second form with this information.