Lauren Kolesa, R.D.
LMK Nutrition, LLC
Tel: 973-539-7700
Fax: 973-366-4018

PATIENT REGISTRATION FORM (Please Print)

First Name __________________ Middle _____ Last Name ___________________________
Home Address:____
City ___________________________________ST_____________ Zip____________________
E-mail ________________________________ Marital status (Circle) S M D Sep W
BIRTHDATE _____/_____/______ AGE ________ Social Security Number___________
PHONE (H) __________________________________Work __________________________
Occupation:____
Employed by:____
Business Address:____
Primary Insurance Company:____
ID NO:_____________________________________ Group NO:_________________________
Name Of Policy Holder:____
Address:____
Home Phone ( )_____________________ Date of Birth_____________________________
Employed by:____
Secondary Insurance Company:____
ID NO:_____________________________________ Group NO:_________________________
Name Of Policy Holder:____
Address:____
Home Phone ( )_____________________ Date of Birth_____________________________
Employed by:____
Referred By/ Doctor _____________________________ Phone _________________________

Referred by: **(Please circle) Doctor Friend/Family Internet Insurance co other**

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APPOINTMENT CANCELLATION POLICY

We take pride in setting aside ample time for each patient in order to allow the Dietitian to provide thorough and comprehensive nutrition assessments. As a result, we limit the number of patients seen on a daily basis. We respect your time and rarely do patients ever wait more than a few minutes for appointments. We also ask that you respect our time as well and cancel your appointment as soon as you discover a schedule conflict. Cancellations made less than 24 hours prior to scheduled appointment times will result in a $50 fee for follow-up appointments and $100 for initial appointments. Health insurance companies will not pay healthcare providers for missed appointments. In addition, this cancellation policy enables patients on our waiting list to obtain an earlier appointment and prevents empty slots in our schedule.

PATIENT AGREEMENT

I agree to contact my health insurance company before my appointment in order to determine the extent of coverage for nutrition services. I acknowledge responsibility for this account and guarantee payment if nutrition services are not covered, if I do not have the requested documentation (i.e. a properly coded medical prescription or a properly coded medical referral) or my health insurance denies payment to Lauren Kolesa. If Lauren Kolesa is not a healthcare provider under my health insurance plan, I agree to pay in full for nutrition services at the time of my appointments.

I understand the above information and agree to provide a minimum of 24 hours for any changes or cancellations to scheduled appointments with Lauren Kolesa. For unpaid balances (i.e. co-pays, fee for nutrition services), there is a $5 monthly billing fee, and for further collections (after 3 months), a 17% interest rate will be added to all outstanding balances.

We work hard to make your experience pleasant, enlightening and the start to a healthier and happier you!

Today's Date: ____________________

Signature of patient or responsible party: ____

Please print your name here: ____