Patient Registration Form

Patient _____

Address _____

_____

Date of Birth _____

Telephone Home _____

Cell _____

Email _____

Occupation _____

Employer _____

Alternate / Emergency Contact _____

Contact Info _____

Referred By: _____

Current Doctor _____

2260 Carillon Point :: Kirkland, WA 98033
P: (425) 828-0100 F: (425) 828-6839 E: Crave@Crave-Health.com
www.Crave-Health.com

Financial Information and Agreements

Insurance Information

Insurance Company:
Primary Card Holder's Name:
Primary Card Holder's DOB:
Member ID#:
Group ID#:
Provider Phone # on Back of Card:

Financial Agreement
Crave Health accepts payment by credit card, cash or check. Crave Health requires payment in full at time of service. Returned checks will accrue an additional $30.00 fee. In case of default on this account, I agree to pay collection costs and attorney fees incurred in attempting to collect on the amount due or any future outstanding balances. My outstanding balances without contributing payments for 90 days will be sent to collections.

Initials_____

Sliding Scale Fee Option N/A ☐
I would like to be considered for Crave Health's sliding scale fee option, based upon my gross monthly income and number of dependents, given below. Should I choose this payment option, I agree to maintain a zero balance by paying in full at time of service. If not, I understand I will be billed Crave Health's full fee for service, of which I have received a copy.

Gross Monthy Income $_____ Number of Dependents_____

_____
I am verifying that the information I have given is correct and I agree to the terms stated.

Signature _____ Date_____

Printed Name: _____

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Office Policies

Cancellation Policy:
Individual appointments are scheduled for a specific time. You will be charged $50 for missed individual appointments unless the RD is notified of cancellation at least 24hours in advance, or in cases of emergency.

Confidentiality:
All information disclosed within sessions is confidential unless specifically released by the patient to a specific person (Primary Care Physician, Parent, etc.) In cases of those under 18 years old, information discussed in sessions may be released to the individuals' parents or guardians without formal release if working with a Medical Provider. If working with a Mental Health Provider, the age of consent and release is 14 years old.

Late Night Appointment Policy:
Appointments that are scheduled for 6pm and later will fall under our "6pm locked door policy." This means that we lock our front door at 6pm, and will be letting clients in as they arrive at the scheduled appointment time. If we are in session and the main door is locked, please feel free to wait inside of Starbucks next door. We will come out and let you in at your designated appointment time.

Medical Insurance:
Medical insurance companies may or may not offer coverage for medical nutrition therapy or mental health counseling. Carefully investigate the type of coverage you have. It is your responsibility to pay for your visit and to have your insurance company reimburse you if applicable. You can be provided with a receipt that you can submit to your insurance company for reimbursement.

I have read and understand the above information.

Signature: _____ Date: _____

Printed Name: _____

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Authorization for Release of Information

Name: _____ Date of Birth: _____

I authorize **Crave Health** to exchange records with my current doctor listed in initial paperwork and:

1. _____
   Name of receiving person, agency or institution

   _____
   Location Contact Info

2. _____
   Name of receiving person, agency or institution

   _____
   Location Contact Info

3. _____
   Name of receiving person, agency or institution

   _____
   Location Contact Info

4. _____
   Name of receiving person, agency or institution

   _____
   Location Contact Info

Signature: _____ Date: _____

Printed Name: _____

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