Client Registration Form

Client Personal Information

Name (First): ____________________________(Last): ___________________________________ (MI):_______

Address: ____________________________________City: _______________ State: ___________ Zip: _______

Email: ____ Phone: _______________________________________

Date of Birth: _______________________________

Preferred Form of Contact: Email Phone

Where can confidential information be left? Email Phone

How did you hear about our office? ____

By whom were you referred?____

Insurance Information (Please attach a photo of the Front and Back of your insurance card with this form)

Primary Insurance Company: ____

Primary Insured's Name: ____

Policy/Member ID #: ____ Group: ________________________

Primary Insured's Date of Birth: _____/_____/_____

Relationship to Client: Self Spouse Child Other

Insured Employer Name: ____

Secondary Insurance Company: ____

Secondary Insured's Name: ____

Policy/Member ID #: _______________________________________ Group: ____________________________

Emergency Contact

Name: ____

Relationship to Client: Self Spouse Child Friend Other _______________________________

Phone #1: ____________________________ Cell Home Work

Client/Guardian Signature ______________________________ Date ___________________

Consent for Treatment and Authorization Form for Use of Protected Health Information Client

Name ____ DOB______________________

Parent/Guardian____(Applies only to patients under 18) I hereby consent to participation in nutrition counseling at Honu Nutrition and understand that information I provide is private, confidential, and protected by law described I the Honu Nutrition Privacy Practices. When necessary to coordinate my nutrition and health care, and as described in the Honu Nutrition Privacy Practices, my protected health information may be obtained form and or provided to my:

Insurance Company ____

Primary Care Doctor ____

Address ____

Phone _____________________________ Fax __________________________

Psychologist or Counselor ____

Address ____

Phone _____________________________ Fax _________________________

Honu Nutrition is hereby released from legal responsibility or liability for the release of information authorized herein. I understand that I have the right to revoke this authorization in writing at any time by sending notification to Honu Nutrition. I understand that I have the right to (1) inspect or obtain a copy or the protected health information to be provided as permitted under federal and state law, and (2) refuse to sign this authorization. My signature indicates my understanding and acceptance of the above policies.

Client Signature ______________________________ Date ____________

Parent/ Guardian _____________________________ Date ____________

Cancellation/Rescheduling Policy & Payment Pre-Authorization

Honu Nutrition requires 48 hours/2 business day advance notice of appointment cancellation & rescheduling. If you are unable to provide the required 48 hour notice you will be charged the full fee of $200 for your missed session. The fee may only be waived in the event of serious or contagious illness or emergency. **Please note that insurance companies do not reimburse for the missed appointments, so payment is the sole responsibility of the client.** *To illustrate this: if your appointment is on Monday at 2pm, we need to hear from you by Thursday at 2pm to avoid the late cancellation charge.*

This also authorizes us to use the credit card information on the file for missing copays or payments not received from insurance such as unmet deductibles or coinsurance. A receipt will be emailed to you should this occur.

Please complete the credit card payment information from below, to be used only in the events as listed above. Please print/type your email address clearly and include your cell phone or the best number for us to reach you.

Please note that your credit card information will remain safe and confidential.

Thank you,
Honu Nutrition

Credit Card number ____

Credit Card type ____

Expiration Date _________/_________ Security Code ________

Billing Zip Code ________

Client name (Please print) ___________________________________

Client Signature ____

Client phone ____

Client Email ____