Welcome to our clinic. Attached are a few necessary forms to be completed prior to your appointment on _____

Please feel free to call us if you have any questions.

We look forward to meeting you and assisting in your nutritional care.

Food 4 Life Nutrition Counseling
5006 Center Street Suite U
Tacoma, WA 98409
253-284-4488

Food 4 Life Nutrition Counseling/South Puget Sound Neurology
5006 Center Street Suite U
Tacoma WA 98409
Office: 253-284-4488 Fax: 253-272-4771

Patient Information
Completion of this information in its entirety is required at time of visit

Name_____ Social security #_____
Last middle first
Marital Status: Single___Married__Divorced___Separated_____ Date of Birth _____
Home Address _____
Street City State zip
Home phone(___)_____ Cell phone (__)_____ M_____ F____
Email address _____
Employer _____ Occupation_____
Employer Address_____ work phone (___)_____
Spouse/Parent name _____Last 4 SSN____ Date of Birth_____
Spouse/parent address _____
Street City State zip
Spouse Employer_____Address_____
Work phone(_____)_____

In case of Emergency:
Relative to contact (other than spouse)_____phone _(_____)_____
Other person to contact (not a relative)_____phone (_____)_____

List other doctors providing care
Referred by _____ phone (_____)_____
Primary Care physician _____ phone (_____)_____
DO YOU WANT A COPY OF YOUR CONSULTATION TO GO TO YOUR DOCTOR? Y N
Have you had X-rays or Lab work in the last six months? Y N
If yes, where were they taken?_____

How do you intend to pay? Cash___ Check_____ Credit Card_____ Insurance_____Other _____
Primary Insurance Co _____ phone (_____)_____
PPO_____ HMO _____
Subscriber _____ID#_____ Group# _____
Secondary Insurance Co _____ phone (_____)_____
PPO_____ HMO _____
Subscriber _____ID#_____ Group# _____

Reason for this visit: Illness_____ Injury_____ job related injury_____Auto____ Other _____
Date of injury or onset of problem_____ Claim # _____
Employer at time of injury _____
Attorney_____ phone_(___)_____ Claim open? Y N

I authorize my insurance benefits to be paid directly to the doctor. I am financially responsible for any balance due. I authorize the doctor or insurance company to release any information required for this claim
Signature_____ Date_____

Obtaining Verbal/Written Permission to Use or Disclose Protected Health Information

From time to time Food 4 Life Nutrition Counseling may wish to use or disclose your protected health information to individuals involved in your care for notification purposes. As stipulated by the Title 45, Section 164.10, we are permitted to make such uses or disclosures **after we have obtained your verbal or written permission.**

Puget Sound Neurology dba Food 4 Life is authorized to: (Please check all that apply.)

- o Notify or speak with my spouse regarding treatment or proposed treatment.
- o Notify or speak to my caregiver regarding treatment or proposed treatment.(names)_____
- o Notify or speak to my family members, i.e., children, siblings, mother, father or proposed treatment.(names)_____
- o Notify or speak to my friend regarding treatment or proposed treatment (names)_____
- o Notify my transportation service regarding my delivery or pick-up to or upon completion of my treatment.
- o Other (please specify)_____

How may we contact you with reference to your appointment, proposed treatment, follow-up appointments, lab testing, radiology and other situations regarding your protected health information? See below:

If I am not available, Food 4 Life dba Puget Sound Neurology may: (please check all that apply)

- o Leave a message with my spouse or those members listed above.
- o Leave a message on my answering machine, voice mail or cell phone.
- o Call my place of employment and leave a message for me to return the call.
- o Leave a message with my interpreter (for foreign speaking patients)
- o Other_____

_____ _____

SIGNATURE **DATE**

_____ _____

PRINT NAME **DATE OF BIRTH**