AMY STEPHENS, MS, RD, CDE

SIGNATURE ON FILE AND PATIENT AGREEMENT

- I authorize and direct you to release government agencies, insurance carriers, or others who are financially liable for my medical care all information needed to substantiate payment for such medical care, and to permit representatives thereof to examine and make copies of all records relating to such care and treatment. In addition, I give permission for your office to leave telephone messages confirming appointments and any other office related manners.
- I authorize payment of medical benefits to Amy Stephens, MS, RD, CDE, CDN for services provided.
- I understand that I am responsible for my bill including any co-pay, co-insurance, deductible under my policy. If my policy has a deductible and it has been applied against your payment from my insurance company, I will pay the deductible directly to you. If I am not insured or my Insurance Company will not authorize or pay for this visit, I understand that I am responsible for my bill.

_____

PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE

_____

DATE

AMY STEPHENS, MS, RD, CDE, CDN

CONSULTING NUTRITIONIST

_____39 ½ Washington Square South, New York, NY 10012 646-391-4868

_____25a Main Street, Hastings on Hudson, NY 10706 646-391-4868

Name:_____Home phone:_____

Address:_____Work phone:_____

City, State, Zip:_____Cell phone:_____

Email:_____SS#:_____

Birthdate:_____Age:_____Sex: M F Marital Status:_____

Height:_____Weight:_____

Type of work:_____

Place of Business:_____

# of children_____Age(s):_____

Do you exercise? Y N Type and Frequency:_____

Referring physician name:_____

Address:_____

Phone:_____

Insurance Company:_____ID#_____

Co-pay?:$_____