**THE FEARLESS FORK**
**MARYBETH JUDY, MS, RDN, CLT, LD**
PATIENT REGISTRATION FORM
(Please print clearly)

| Today's Date: | PCP: |
|---|---|

**PATIENT INFORMATION**

| Patient's last name: | First: | Middle Initial | Marital status (circle one)<br>Single / Mar / Div / Sep / Wid |
|---|---|---|---|

| Email address: | Cell phone: | Home phone: | Birth date:<br>/ / | Sex:<br>❑ M ❑ F |
|---|---|---|---|---|

| Street address: | Social Security no.: | Home phone no.:<br>( ) |
|---|---|---|

| P.O. box: | City: | State: | ZIP Code: |
|---|---|---|---|

| Occupation: | Employer: | Work phone.: |
|---|---|---|
| | | ( ) |

**Referred By:** ❑ Dr. ❑ Hospital ❑Insurance ❑ Self

❑ Family ❑ Friend ❑ Close to home/work ❑ Internet Site please specify:

**Reason for Visit:**

**INSURANCE INFORMATION**

Please provide a copy of the front and back of your insurance card.
Or, bring your card if meeting in person.
If you will be paying cash, you do not need to complete this section.

| Person responsible for bill: | Birth date:<br>/ / | Address (if different): | Home phone no:<br>( ) |
|---|---|---|---|

| Occupation: | Employer: | Employer address: | Employer phone no.:<br>( ) |
|---|---|---|---|

Is this patient covered by insurance? ❑ Yes ❑ No Effective Date::

Please indicate primary insurance

❑ Aetna HMO ❑ Aetna PPO ❑ Anthem BCBS of Maine ❑Medicare Part B
❑ Other please specify:

| Subscriber's name: | Subscriber's S.S. no.: | Birth date:<br>/ / | Group no.: | Policy no.: | Co-payment:<br>$ |
|---|---|---|---|---|---|

Patient's relationship to subscriber:
❑ Self ❑ Spouse ❑ Child ❑ Other

| Name of secondary insurance (if applicable): | Subscriber's name: | Group no.: | Policy no.: |
|---|---|---|---|

| Patient's relationship to subscriber:<br>❑ Self ❑ Spouse ❑ Child ❑ Other |
|---|

| IN CASE OF EMERGENCY | | | |
|---|---|---|---|
| Name of local friend or relative (not living at same address): | Relationship to patient: | Cell or home phone no.:<br>( ) | Work phone no.:<br>( ) |
| The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to The Fearless Fork LLC. I understand that I am financially responsible for any balance. I also authorize The Fearless Fork LLC and the owner, Marybeth Judy MS, RDN, CLT, LD or the insurance company to release any information required to process my claims.<br><br>*Patient/Guardian Signature* *Date* | | | |

A message:
❑ can ❑ cannot be left on my home phone.
(Please check a box.)

**Informed Consent:**

I am employing the services of Marybeth Judy, Registered Dietitian Nutritionist, Certified Leap Therapist and Licensed Dietitian so that I can obtain information and guidance about health factors within my own control (diet, nutrition, and related behaviors) in order to nourish and support my health and wellness. I understand that Marybeth Judy RDN, CLT, LD does not dispense medical advice nor prescribe treatment. Rather, she provides education to enhance my knowledge of health as it relates to foods, and behaviors associated with eating. I understand nutrition counseling is not a substitute for the diagnosis, treatment, or care of disease by a medical provider. Nutritional evaluation or testing that is done as part of my assessment is not intended for the diagnoses of disease. Rather, these assessment tests are intended as a guide to developing an appropriate health-supportive program for me, and to monitor my progress in achieving my goals. I agree to hold Marybeth Judy RDN, CLT, LD harmless for claims or damages in connection with our work together. This is a contract between myself and Marybeth Judy RDN, CLT, LD, and I understand that it is also a release of potential liability.

Printed Name: ______________________________________________

Signature: ____________________________Date: ________________________

**Privacy Practices Acknowledgment:**

The Fearless Fork requires your consent to use and disclose your protected health information to carry out treatment, payment and healthcare operations. You have the right to restrict how Private Health Information is used or disclosed for treatment, payment or healthcare operations. Please review the Notice of Privacy Practices thoroughly before signing this acknowledgement form.

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I acknowledge that the Notice of Privacy Practices has been sent as attachment with this email or has been provided to me by Marybeth Judy RDN, LD in paper form. I have also been advised that I can read and download Notice of Privacy Practices by going to the Office Info tab on www.thefearlessfork.com.

By signing below, I hereby acknowledge receipt of the Notice of Privacy Practices and consent to the use of my protected health information for treatment, payment and health care operations. I acknowledge receipt of a copy of this Consent if requested. I acknowledge that I have the right to revoke this consent in writing and the revocation will be effective except to the extent The Fearless Fork has acted with reliance on my signed consent.

**Authorization to Release and Discuss Healthcare Information:**

I authorize Marybeth Judy MS, RDN, CLT, LD to release and discuss my nutritional counseling sessions, goals, and education to my medical doctors via fax, email, phone call or any other forms of communications.

I also give my consent for my medical doctors to release and discuss any pertinent lab work, appointment details, and/or any other medical information that is relevant to my overall nutrition treatment goals.

Printed Name: ______________________________________________

Signature: _________________________Date: _____________________

Thank you!