LORI KOLODIN, MPH, RD
REGISTERED DIETITIAN IN PRIVATE PRACTICE

784 Chimney Rock Road, Suite H2
Martinsville, New Jersey 08836
PHONE 908-403-7636
FAX 908-222-0020
LSKNUTRITION.COM

PATIENT INFORMATION – PLEASE PRINT CAREFULLY

NAME:

ADDRESS:

CITY:

STATE: ZIP:

TELEPHONE:

EMAIL:

DATE OF BIRTH:

INITIAL VISIT DATE:

OCCUPATION OR STUDENT:

HOW MANY IN YOUR HOUSEHOLD?

REFERRED BY:

REASON FOR VISIT:

PRIMARY HEALTH INSURANCE:

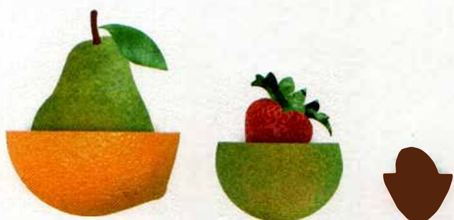
NAME & DATE OF BIRTH OF THE POLICY HOLDER:

RELATIONSHIP TO PATIENT: SELF SPOUSE PARENT OTHER

INSURANCE ID & GROUP NUMBERS:

ADDRESS OF INSURANCE COMPANY:

ADDITIONAL INSURANCE: YES NO



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FINANCIAL POLICY

The purpose of my practice is to provide you with the best possible care. If you have health insurance, I am committed to helping you receive maximum allowable benefits. In order to achieve these goals, I need your assistance and understanding of my payment policy.

It is the patient's responsibility to verify their health insurance benefits prior to the initial visit. Being in network does not guarantee reimbursement of professional services rendered. All referrals, authorizations and copayments are due at the time of service. It is the patient's responsibility to understand how their insurance policy works by knowing what is expected of them in terms of referrals, copayments, authorizations, deductibles and covered services.

Cancellations less than 24 hours prior to scheduled appointments will be charged a $40.00 fee unless a true emergency occurs.

I understand and agree that regardless of my insurance status, I am ultimately accountable for all charges regarding professional services rendered to myself or my dependent. I have read the information above and verify that all information is correct on my patient information sheet. I hereby give Lori Kolodin, MPH, RD permission to release my or my dependent's medical records to my insurance company should they request additional information.

Signature: Date:

Print Name:

Parent's Signature (if minor):

Print Name: Date: