# Ingrid Knight, RD and Associates, Inc.

Nutrition Therapy, Consulting

**Welcome to our office!**
**If you must cancel or change an appointment, call as soon as possible. For an appointment missed or cancelled less than 24 hours in advance, there is a $25 fee. This fee is not reimbursed by insurance.**

**New Patient Registration** **DATE :** _____

| | | | | | |
|---|---|---|---|---|---|
| Name | | Date of birth | | Age | |
| Address | | City/State/Zip | | | |
| Referred by: | | Responsible party | Emergency Contact/Phone | | |

## Contact Information

| | | | |
|---|---|---|---|
| Mobile Phone | | Alternate phone | |
| **How would you like to be contacted? ☐ Phone ☐ Text ☐E-mail** | | | |
| E-mail Address | | **Add to newsletter e-mail list**? Y N | |

## Insurance Information

| | | | |
|---|---|---|---|
| **Primary insurance** | | Phone # Address | |
| Policy number | | Group number | |
| Subscriber's name | | Relationship to Subscriber | |
| **Secondary Insurance** | | Policy Number | |

## Primary Care Physician

| | | | |
|---|---|---|---|
| Name | | Phone # | |
| Address | | | |
| What did you last see him/her for? When did you last see him/her? | | | |

## Other Physician or Specialist

| | | | |
|---|---|---|---|
| Name | | Location | |
| What did you last see him/her for? When did you last see him/her? | | | |

- **Office locations in Athens, Cumming, Marietta and Eastman, Georgia**
- **Virtual Video Consulting available to all Georgia and South Carolina residents**
- **Most insurances accepted**

**Call: 404-725-0808 (administration)**
E-mail: info@ingridknightrd.com
1026 Twelve Oaks Drive, Ste A
Watkinsville, GA 30677
FAX 1-855-449-4606
www.ingridknightrd.com

# Ingrid Knight, RD and Associates, Inc.

Nutrition Therapy, Consulting

**Statement of Patient Financial Responsibility**
**Consent for Medical Nutrition Therapy**
**Receipt of Privacy Policy**

**Patient Name:** _____

**Date of Birth:** _____

## CONSENT FOR MEDICAL NUTRITION THERAPY

Medical Nutrition Therapy encompassing all nutrition assessment, nutrition diagnosis, nutrition interventions and nutrition monitoring considered necessary or advisable in the judgment of the Registered, Licensed Dietitian and/or the Physician. I am aware that nutrition is not an exact science, and I acknowledge that no guarantees have been made to me as to the result of interventions.

## PATIENT FINANCIAL RESPONSIBILITY

This is a statement of our financial policy. You understand that you are obligated to ensure that our fees are paid in full. We will verify your coverage and bill your insurance carrier on your behalf. However, you are ultimately responsible for payment of your bill at current hourly rates, listed on services list available in-office.

You agree that you will pay any deductible and co-payment or co-insurance as determined by your insurance plan. Those payments will be due at the time of service. Many insurance companies have additional requirements or stipulations that may affect your coverage. You are responsible for any amounts not covered or payable by your insurance. If your insurance denies any part of your claim, you agree to be responsible to pay the full balance.

FORMS OF PAYMENT ACCEPTED: Check, cash, credit cards (with added 3% fee)

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**ACKNOWLEDGEMENT:**

I have read and understand the financial policy and consent for medical nutrition therapy as described above. I agree to pay, promptly and in full, any amounts due to the provider, including co-payments, deductibles, and amounts due for non-covered or services that are not payable by my insurance.

**PATIENT WRITTEN ACNKOWLEDGEMENT CONFIRMING RECEIPT OF PRIVACY NOTICE**

I have received the HIPAA Privacy Notice for the office of INGRID KNIGHT, RD and Associates, Inc. **available in the reception area of the office**.

Patient Signature:

_____ Date: _____

Authorized Representative Signature:
(Use if patient is a minor or otherwise has an authorized representative.)

_____ Date: _____

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