

Central Oregon Nutrition Consultants

Lori S. Brizee MS, RD, LD, CSP
61456 Elder Ridge St, Bend, OR 97702
lbrizee@bendbroadband.com
541-388-0694

New Patient Information

Name: _____ Date: _____
Address: _____ City: _____ State: _____ Zip: _____
Tel#: **Home** _____ **Work:** _____ Best Time/Place to call? _____
Birthdate: _____ Sex: Male Female
Referring doctor/nurse practitioner/physician assistant: _____
Student: Y N Full Part-time Marital Status (please circle one) M S W D
Occupation: _____ Employer: _____
Employer's Address: _____ City: _____ State: _____ Zip: _____
Spouse or Parent's: Name _____
Occupation: _____ **Employer:** _____
Employer's Address: _____ City: _____ State: _____ Zip: _____
Person responsible for payment on this account: _____

Insurance Information.

Do you have any group, union or personal health and accident insurance? Yes No
Name of Insured: _____ Relation to patient: _____ Policy# _____
Insurance Co.: _____ Group # _____ ID #(if any) _____
Address: _____ City: _____ State: _____ Zip: _____
Phone: _____
Additional Insurance Company (if any): _____ Group # _____
Name of Insured: _____ Relation to patient: _____ Policy # _____
Address: _____ City: _____ State: _____ Zip: _____

FINANCIAL POLICY *Read Carefully and Sign Below*

I clearly understand and agree that I am personally responsible for payment of all services rendered to me by Central Oregon Nutrition Consultants. I agree to allow Central Oregon Nutrition Consultants to bill my insurance company as a courtesy, permit the release of records necessary to process my claims, and authorize payments to be made directly to Lori S. Brizee for services rendered. I further understand that co-payments are due at time of service and that I will subsequently be billed for all charges not covered by my insurance company. **Payment in full is due at time of service for clients without insurance coverage for nutrition therapy.**

Cancellation policy: Lori Brizee must receive an e-mail or telephone cancellation at least 24 hours before appointment. Missed appointments or cancellations with less than 24 hours notice are billed at the rate of \$136..

I have read and understand the above financial and cancellation policies.

Client's Signature: _____ Date: _____

Parent or Guarantor's Signature: _____ Date: _____