Client Registration Information - FEED TO SUCCEED, LLC

(Please Print/Type)

Client Info:

Last Name: _____ First Name: _____

Birthdate: _____ Gender: _____

Primary Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____--_____--_____

Primary Physician Info:

Name: _____ *Physician Phone:* _____--_____--_____

Name of Practice: _____ *Physician Fax:* _____--_____--_____

City/State: _____

Primary Contact Info:

Name: _____ **Relationship:** _____

Address (if different): _____

Email Address: _____ Work Phone: _____--_____--_____

Cell Phone: _____--_____--_____ ***Preferred Contact:*** Email Cell Phone Home Phone Work Phone

Secondary Contact Info:

Name: _____ **Relationship:** _____

Address (if different): _____

Email Address: _____ Work Phone: _____--_____--_____

Cell Phone: _____--_____--_____ ***Preferred Contact:*** Email Cell Phone Home Phone Work Phone

Parent Marital Status: Single Married Widowed Divorced Partner

Client Primarily Living With: Both Parents Mother Father Other: _____

Insurance Info:

Subscriber Name: _____ Subscriber DOB: _____

Subscriber Employer: _____ Occupation: _____

Insurance Company Name: _____ Group #: _____

Insurance Provider Call #: _____--_____--_____ ID #: _____

How did you find F2S? _____

I HEREBY:

1. Certify that I have received and reviewed a copy of the HIPAA privacy notice.
2. Certify that I am responsible for all services rendered to me and/or members of my family.
3. Certify that I am responsible for any late fees if my balance is not paid within 30 days and/or collection fees of 25% if my balance is not paid within 90 days of service.

Parent/Guardian Signature: _____ Date: _____/_____/_____

Office Use Only: ___ ***HIPAA*** ___ ***Cancel*** ___ ***Card*** ___ OA ___ Doctor ___ Client ___ VoB ___ Scan Date: _____ Initial: _____