2001 Marcus Ave.
Suite E240
New Hyde Park, NY 11042

STACIE CASTLE
nutrition

Phone: (516) 652-2747
Fax: (516) 935-2058
www.staciecastlenutrition.com

Patient Name ____ SSN ________________________

Street Address ______________________________________ Date of Birth ___________Age_________

Town/City ____________________ State ____________ ZIP _________________ Gender M F

Home Phone __________________ Work Phone _____________________ Mobile _________________

A message can be left on my__________ phone. E-Mail ______________________________________

Occupation ________________________________ Employer's Phone ___________________________

Marital Status ________________ Spouse's Name _______________ Phone # _____________________

Referring Doctor __________________________________ Phone # _____________________________

Employer's Name ____ Phone # ___________________

Spouse (or Parent) Employer's Name ___________________________ Phone # ___________________

Primary Insurance Company Name _______________________________ ID # ____________________

Telephone # on back of Card ____

Insured's Name ___________________ Date of Birth ____________ Relationship to patient __________

Address (if different) ____

Do you have any other Insurance? YES NO (if yes, list name and ID #) ________________________

Privacy Consent, Authorization for Treatment, Payment and Healthcare Operations

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

I agree to pay Stacie Castle, MS, RD, CDN in a timely and current manner, any balance of medical charges and expenses such as services not covered by insurance plan, copays and/or deductibles that are the patient's responsibility.

If you require a referral to see a specialist on your plan – **you must present the referral form at the time of visit.**

Medicare B Patients:

"I request that payment of authorized Medicare benefits be made to Stacie Castle, MS , RD, CDN for any services furnished to me. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits of the payable for related services."

I have received a copy of the most current Notice of Privacy Practices. Please Initial _______

PATIENT'S (Or Authorized) SIGNATURE___________________________________ DATE ________________________