Erica Leon Nutrition LLC

297 Knollwood Road, Suite 304
White Plains, NY 10607
(914) 693-2174

Patient Registration Information

Today's Date:_____

Name of Patient:_____

Male:_____ Female:_____Date of Birth:_____Age:_____

Patient Cell Phone:_____Patient email:_____

If in school, Name of School:_____Grade:_____

Name of Parents(if relevant):_____ Home Ph:_____

Parent Cell:_____Parent email:_____

Home address:_____

City/State/Zip:_____

If patient is not responsible for payment, please answer the following:

Who is responsible for this account? _____

Print full name:_____

Relationship to Patient _____

Employer:_____

Job title:_____

Business Address:_____

City, State, Zip_____

Erica Leon, MS, RDN, CDN
www.ericaleon.com
erica@ericaleon.com

Erica Leon Nutrition LLC

297 Knollwood Road, Suite 304
White Plains, NY 10607
(914) 693-2174

Appointment Procedures and Cancellation Policies

1) 24-hour notice must given for all cancellations or you will be charged for the session in full. This time is reserved just for you and we are unable to fill this slot on short notice.

2) Payment is expected at the time of your appointment. Checks, cash or credit cards are accepted. Checks are to be made out to: Erica Leon Nutrition LLC.

3) Medical Insurance Companies may offer coverage for nutritional counseling. Please check with your provider to see if they reimburse for medical nutrition therapy/nutrition counseling. We will be happy to assist you in determining coverage. However, please understand that it is your responsibility to pay for your nutrition session if your insurance plan does not.

4) Payment for sessions includes communication with other members of your health care team as needed; however, extensive phone conversations and/or emails will be billed accordingly.

5) A full hour appointment is really 50 minutes; 45 min appointments are 40 minutes and a full half hour appointment is 25 minutes.

I hereby acknowledge responsibility for this account and assume and guarantee payments of all charges against this account if they accrue. If my insurance claims are rejected and nutrition counseling is not a covered service, I accept full responsibility for payment of these fees. ***I also understand that for any outstanding balance that goes beyond 30 days of non-payment, I will be billed an additional 2% monthly on the portion of the bill that remains outstanding***

Signed_____Date_____

Erica Leon, MS, RDN, CDN
www.ericaleon.com
erica@ericaleon.com

Erica Leon Nutrition LLC
297 Knollwood Road, Suite 304
White Plains, NY 10607
(914) 693-2174

Authorization for Release of Information

I _____ (print your name), authorize Erica Leon, MS, RDN, CDN, OR Elyse Falk, MS, RD, CDN, of Erica Leon Nutrition LLC, to contact and/or release information concerning my nutrition therapy to the following physicians/therapists:

1) Name_____Phone #_____

2) Name_____Phone #_____

3) Name_____Phone #_____

4) Name_____Phone #_____

Signature: _____

Print name: _____

Parent/guardian if under 18: _____

Date: _____

Phone Number: _____