ASPIRE
Nutrition & Wellness

PRE-VISIT CLIENT ASSESSMENT FORM

Thank you so much for your interest in nutrition counseling from ASPIRE Nutrition & Wellness. Please fill out this form to collect important information before your first appointment. If you are under 18 years old, please fill this out with the help of a parent.

PERSONAL INFORMATION

Name: _____

Date of Birth: _____ Age: _____

Occupation: _____

Reason for Visit: _____

How did you hear about us? _____

CONTACT INFORMATION

Preferred method of contact (circle one): Cell Phone / Home Phone / Email / Text Messaging

Home Phone Number: ( ) _____ May I leave a message? Y / N

Cell Phone Number: ( ) _____ May I leave a message? Y / N

May I leave a text message? Y / N

Email address: _____

Home address: _____

City, State, Zip: _____

Emergency Contact Name: _____

Phone Number: ( ) _____

Relationship to Client: _____

If under 18: Parent/Guardian(s)

Name(s): _____

Contact Information: _____

ASPIRE
Nutrition & Wellness

AUTHORIZATION FOR RELEASE OF INFORMATION

I authorize ASPIRE Nutrition & Wellness to release my protected private medical and health information to the below providers concerning my care. I understand I can revoke this authorization at any time by providing written notice to ASPIRE Nutrition & Wellness.

I authorize: Christine Elkhoury, MBA, RD, LDN
ASPIRE Nutrition & Wellness, LLC
2000 Town Center, Suite 1900. MI 48075

to exchange records (provide and receive information) with the following providers:

Therapist: _____
Name of receiving person, agency or institution

_____
Phone *Email*

Primary Care Physician: _____
Name of receiving person, agency or institution

_____
Phone *Email*

Specialty Physician: _____
Name of receiving person, agency or institution

_____
Phone *Email*

Other: _____
Name of receiving person, agency or institution

_____
Phone *Email*

_____ _____
Client Name (print) *Date*

_____ _____
Client Name (signature) *Date*

_____ _____
Parent/Guardian Name (print) *Date*

_____ _____
Parent/Guardian Name (signature) *Date*

ASPIRE
Nutrition & Wellness

OFFICE POLICY INFORMATION- UPDATED NOVEMBER 2016

Confidentiality: All information disclosed within sessions is confidential. If we see you outside the office in a public setting (ex. Grocery store, restaurant, etc.) we will respect your privacy and will NOT initiate a conversation. We will exchange information with your team of professionals ONLY by signing the Authorization to Release Information form.

Payment: Non-refundable payment is expected in full by cash, credit card, or check on the day of the appointment.

Medical Insurance: Insurance companies may or may not cover medical nutrition therapy. Although ASPIRE Nutrition & Wellness does not accept insurance payment for sessions, it is important to carefully investigate the "out of network" coverage you have for possible reimbursement.

Cancellations: We value and respect your time as a client and ask for the same in return by arriving on time to appointments and giving advanced notice when you are unable to attend your appointment. We kindly request a 24 hour notice to cancel or reschedule an appointment. If you are unable to arrive to the office though are able to attend your appointment over the phone or via Skype please call ahead and we will be happy to accommodate.

All cancelations outside of the time boundary are subject to be charged the full amount of the appointment scheduled.

Please note that all cancelation and rescheduling for appointments can be received by a phone call or email. WEATHER CANCELLATIONS: We will close the office if local schools are closed and therefore our appointment will be rescheduled with no charge. If requested, we may have a phone session in replacement.

A credit card is required to hold appointments and will not be charged unless an appointment is missed without proper cancelation.

Name on Card	
Card Number	
Expiration Date	
3 digit Security Code (usually located on back)	
Billing Address Zip Code	

I have read and understand the above information. I agree to authorize ASPIRE Nutrition & Wellness to collect a fee from my credit card account based on the information provided above. No refunds are given under any circumstances. A copy was provided to me for my records.

Client Name (Print)	*(Signature)*	*(Date)*
Parent/Guardian Name (Print	*(Signature)*	*(Date)*