

Patient Information
Kellie Berry Nutrition, Inc.

First Name:	Middle Initial:	Last Name:
Street Address:	City:	State and zip code:
Date of birth:	phone number:	email address:
Sex Assigned at birth (as listed on your insurance policy and used for billing): <ul style="list-style-type: none"> <input type="radio"/> Male <input type="radio"/> Female <input type="radio"/> X/Nonbinary <input type="radio"/> Prefer not to say 	Pronouns (optional):	Gender Identity (optional): <ul style="list-style-type: none"> <input type="radio"/> Woman <input type="radio"/> Man <input type="radio"/> Nonbinary <input type="radio"/> Prefer to self describe: _____ <input type="radio"/> Prefer not to say
Emergency contact name:	Emergency contact phone:	Emergency contact address:
		Relationship to client:
Primary Insurance:	Insurance phone:	Insurance address:
Insurance ID number:	primary insurance copay:	
secondary insurance:	Secondary Insurance ID:	secondary insurance phone and address:
Patient name:	Date:	Patient Signature:
Parent/guardian name:	Date:	Parent/guardian signature:

*It is the Patient's responsibility to contact their insurance company to ensure nutrition counseling sessions are covered. If for any reason the nutrition counseling sessions with Kellie Berry Nutrition, Inc. are not covered, the patient is liable for the full cost of the session, by signing above I agree to pay any balance not covered by my insurance. By signing this form I also agree to allow this information to be released to third parties for billing purposes.