WENDY MEYER STERLING, MS, RD, CSSD, CDN
Tel: 917-568-9695 Fax: (866) 345-2420
WendyMSRD@yahoo.com
www.sterlingnutrition.com

STERLING NUTRITION

PATIENT'S NAME: **DOB:**

ADDRESS:
City/State/Zip:

EMAIL:

HOME PHONE:

CELL:

* If minor, please fill out
PARENTS' NAME

EMAIL

CELL

WORK:

REFERRED BY:

REASON FOR REFERRAL:

WENDY MEYER STERLING, MS, RD, CSSD, CDN
Tel: 917-568-9695 Fax: (866) 345-2420
WendyMSRD@yahoo.com
www.sterlingnutrition.com

STERLING NUTRITION

Consent to Release Information

PATIENT'S NAME: DOB:

I, _____(patient's name or parent's name if minor) consent to release information regarding the nutrition care of _____ (patient's name), as well as any other relevant information **to or from** the following individual(s):

PROVIDER'S NAME	TITLE	CONTACT INFORMATION

Signature: _____ Date: _____
(parent to sign if minor)

WENDY MEYER STERLING, MS, RD, CSSD, CDN
Tel: 917-568-9695 Fax: (866) 345-2420
WendyMSRD@yahoo.com
www.sterlingnutrition.com

NEW PATIENT INFORMATION

PAYMENT:

Payment is expected at the time of your appointment. Checks are to be made payable to **Wendy Sterling, MS, RD**.

APPOINTMENT:

Individual appointments are scheduled for a specific time. **You will be charged in full for missed appointments unless you notify me within 24 hours.**

MEDICAL INSURANCE:

Medical Insurance Companies may offer coverage for nutrition therapy. Please check with your insurance provider to see if they provide reimbursement for medical nutrition therapy. However, you are responsible for payment of fees at time of visit.

I hereby acknowledge responsibility for this account and assume and guarantee payments of all charges against this account if they accrue.

Signature: _____ Date: _____

STERLING NUTRITION

WENDY MEYER STERLING, MS, RD, CSSD, CDN
Tel: 917-568-9695 Fax: (866) 345-2420
WendyMSRD@yahoo.com
www.sterlingnutrition.com

I have received Wendy Meyer Sterling, MS, RD, CDN's HIPAA Privacy Notice.

Patient's Signature: _____

Parent's Signature: _____
*only if patient is a minor:

Print Name: _____

Date: _____