Nutrition As Therapy Inc (Please fill out grey areas/Llenar areas en color gris)

Patient's Demographics Information			
Patient's Last Name (Apellido del Paciente)	**Patient's First Name (Primer Nombre del Paciente)**		**MI**
DOB (Fecha de Nacimiento)	**Gender (Sexo)**	**Social Security Number (Seguro Social)**	
Address (Domicilio)			
Zip Code (Codigo Postal)	**Email Address (Codigo Postal)**		
Home Phone (Numero de telefono)	**Mobile (Numero celular)**		
REFERRING PHYSICIAN: (Doctor que lo refirio)	**PATIENT'S DRIVER'S LICENSE #: (Numero de licencia suya)**		
REFERRAL DIAGNOSIS: (Diagnostico)	**(Si el Paciente is menor, Seguro Social de pariente)**		

Primary Insurance Information			
Subscriber's Last Name (Apellido de subscritor)	**Subscriber's First Name (Primer Nombre de Subscritor)**		**MI**
Subscriber's Date of Birth (DOB) (Fecha de Nacimiento)	**Subscriber's Social Security Number (Subscritor Seguro Social)**		
Insurance Name (Nombre de el Seguro)			
Subscriber's ID (Numero de Identificacion del Subscritor)	**Group Number (Nombre del grupo del Subscritor)**		
	Insurance Phone Number (numero del Seguro)		

Secondary Insurance Information			
Subscriber's Last Name (Apellido de subscritor)	Subscriber's First Name (Primer Nombre de Subscritor)		MI
Subscriber's Date of Birth (DOB) (Fecha de nacimiento)			
Insurance Name (Nombre de Seguro Medico)			
Subscriber's ID (Numero de Seguro)	Group Number (Nombre del grupe del Subscritor)		
Patient's Relationship to the Insured (Relacion con el Asegurado)	Insurance Phone Number (Numero del Seguro)		

Name of Local friend or relatives not living in the same address (Nombre de un amigo a familiar que no vive en su hogar)	Relationship to Patient (Relacion a usted?)	Home Phone (Numero de telefono)	Mobile Phone (Celular)

ELIGIBILITY TYPE

☐ Month to Month ☐ Yearly

Reference number given for eligibility and copay info	**Authorization Number**

SCAN BOTH SIDES OF THE INSURANCE CARD

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to my therapy provider. I understand that I am financially responsible for my balance. I also authorize Nutrition as Therapy Inc, or my insurance company to release information required to process my claims.

Patient/Guardian Signature(Firma del Paciente) **Date(Fecha)**