Client Information

Title: __________ Full Name: ____

Date of Birth: ____________________

Guardian (if under 18 years of age): ___________________________

Residential Address: ____

____ Post Code:__________

Phone: Home: _________________

Work: _______________

Mobile: _________________

Email: ____

Are you happy to receive diet and lifestyle information from Nutrition Health Experts via email?

Yes No

Did a medical practitioner refer you? (A referral is not essential)

Yes No

Referring Practitioner's Name: ____

Referring Practitioner's Clinic Address: ___________________________________

____

Payment is required on the day of service

HICAPS payments are accepted at our consulting rooms and rebates processed at the time of payment

Note: Patients funded by a GP Management Plan are responsible for their account in the event of Medicare rejecting the claim.

How did you find out about Nutrition Health Experts?

Medical Practitioner Internet Search Social Media Yellow Pages

Dietitian's Association Advertising Word of Mouth Other________

HOW WE PROTECT YOUR PRIVACY

We collect information about your health in order to make dietary recommendations. We collect information provided by you and your referring medical practitioner. We may post a letter to your referring medical practitioner following your visit to our health service. Personal information is kept confidential. We use personal information collected for individual assessments and managing payments. You can access your health record at any time and if you feel it is inaccurate, we will correct the information.

We require your consent to collect your health information. Please sign and date this form below.

Signature: ___________________________ Date: ________________