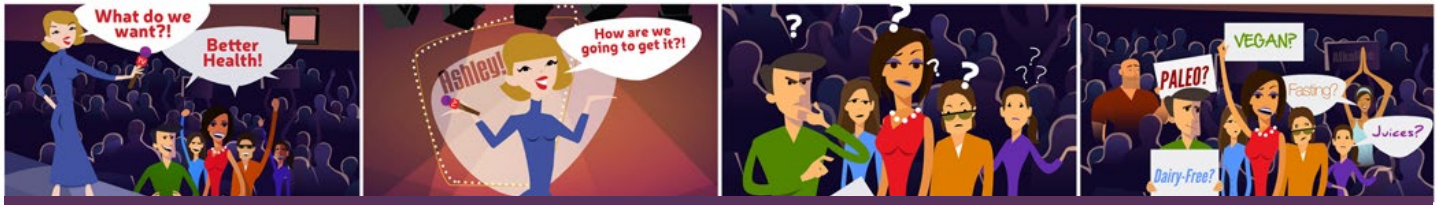

Ashley Koff$_{RD}$ NEW PATIENT FORM

Full Name :

Phone (best # to reach you) : 2nd # :

Email address : Age :

Referred by :

What can Ashley help you with?

What are your personal health goals for one year from now? 5 years from now?

Medical History: Please list any diseases, medical conditions, or physical ailments current or in your past; Please attach any recent lab work (last three years) you have available.

Please list: any medications and dietary supplements you currently take / use (includes fiber, protein, pills, powders, teas, shakes, etc.), when you take them and the approximate length of time for which you have done so. Take pictures of the front and back of each supplement & include those photos with this form.

Who or what makes you laugh?

Please describe your current activity schedule (use what you did last week) and note any limitations (pain, injuries, etc.)

Please list any known food allergies / sensitivities / foods you avoid & the reason (can be dislike or for religious reasons)

Please describe your weight history (approximate weight each decade beginning with childhood, self-perception, and, if applicable, diet type & results)

Please complete a food journal for a minimum of 3 days (ideally one weekend and one weekday are both included). Please note what you consumed and when, you may choose to describe any adverse feelings (I felt bloated, I was tired) before or after that consumption. Please include all beverages.

DAY 1 :

DAY 2 :

DAY 3 :

Ashley Koff$_{RD}$ LLC Patient Agreement

PLEASE READ & SIGN BELOW CONFIRMING YOUR AGREEMENT TO THE FOLLOWING:

1. I agree that all the information presented here is truthful to the best of my knowledge.

2. I agree to a 24 hour cancellation policy via email to AKA@AshleyKoffApproved.com for which you MUST receive a confirmation of the cancellation by Ashley Koff$_{RD}$ or representative.

3. Failure to cancel within 24 hours means you may be billed for all or some of the appointment at the discretion of Ashley Kof$_{RD}$ LLC.

4. I agree to maintain the privacy of other patients or staff I may encounter at the Ashley Kof$_{RD}$ LLC clinic(s) by not disclosing their names to friends, family, colleagues or members of the media at any time. This includes taking pictures or posting on social media in any format.

5. Please note that we will use email as our primary form of communication. In the event that you do not receive an email response in a timely manner (48 business hours from when you sent yours) nor do you receive an out of office / office closed notification with date of return to service, please contact us by phone at the number provided when you made your appointment. Things happen with electronic mail and we want to do our best to make sure we address any questions and respond to any communication in a timely manner, so we appreciate your help to avoid communication failures.

6. Please provide a valid credit card to confirm your appointment. You will NOT be charged until the time of your scheduled appointment; in the event you fail to cancel, you will be notified via email and billed at that time.

Credit Card # :

Exp. Date : Security Code : Billing Zip Code :

Patient Signature :

Date :

From Ashley :

Thank you. In exchange for your efforts, I agree to make my best effort to help you achieve your personal health goals. I look forward to working with you!

— Ashley Koff$_{RD}$

ashleykoff RD