

CHKD Registration Form
Healthy You Weight Management Program

CHILD AND ADULT INFORMATION

Child's Name: _____ SS# _____ Today's date _____
Parent or Guardian's Name: _____ Date of birth _____ SS# _____
Relationship to Child _____
Home Phone: _____ Cell Phone _____ Work Phone _____
Mailing Address: _____ City/State _____ Zip Code _____
Parent or Guardian's Employer: _____
Employer address and phone number: _____
Parent or Guardian's occupation: _____
Parent's Email _____ Child's Email _____
Age of Child _____ Date of Birth _____ Place of birth _____ Male / Female
Child's Doctor, Address, and Phone _____

Starting Date of the Healthy You Intensive Lifestyle Class You are Interested In _____

REGISTRATION INSTRUCTIONS

Insurance coverage?: Yes / No (Limited tuition assistance is available depending on income guidelines).

Please send copy of front and back of insurance card and list the following:

Primary Insurance Name: _____ **Insurance Phone #** _____

Policy Holder Name _____ **Policy Holder SS#** _____

Policy Holder Date of Birth _____

Group policy # _____ **Policy ID #** _____

Secondary Insurance Name: _____ **Insurance Phone #** _____

Policy Holder Name _____ **Policy Holder SS#** _____

Policy Holder Date of Birth _____

Group policy # _____ **Policy ID #** _____

Other insurance? Please write information on the back.

***Healthy You clinic** visits will be billed to your insurance. You will be responsible for your regular co-pay, insurance deductible and any balance after insurance reimbursement.*

***Healthy You Intensive 10 week lifestyle classes** are not generally covered under insurance and are an out of pocket expense. You may pay that with your non-refundable check, money order or credit card payment for \$350.00 payable to CHKD. Payment plans, scholarships and fee adjustments are available.*

CREDIT CARD INSTRUCTIONS

If paying by credit card, please complete the information below.

Credit Card: Master Card VISA American Express

Credit Card # _____

Expiration Date: _____ Amount of payment: _____

Name as it appears on card (please print) _____

Signature: _____

MAILING INSTRUCTIONS

Mail this completed registration form, copy of insurance card and payment to:

Healthy You Program c/o Children's Hospital of The King's Daughters
601 Children's Lane
Norfolk, VA 23507

Questions? Call 757-668-7035

