CONSENT FOR TREATMENT

TKS Nutrition, LLC
Healthy Habits for Life

I consent to treatment from TKS Nutrition, LLC. I grant permission to the dietitians, employees and other persons authorized by TKS Nutrition, LLC to render routine medical care that includes, but is not limited to, medical nutrition therapy, diagnostic procedures and medical consultation, and to carry out all orders deemed advisable by my attending or treating physician. I understand that no guarantee or assurance has been made as to the results that may be obtained.

CONSENT TO RELEASE INFORMATION

I hereby consent to the use and disclosure of my health information for treatment, payment and health care operations purposes as described in the TKS Nutrition, LLC Notice of Privacy Practices.

FINANCIAL RESPONSIBILITY

I certify that I have no insurance which will pay benefits for medical nutrition therapy and assume full responsibility for payment or I certify that the insurances(s) reported herein for this service is/are a complete listing. I understand that failure to disclose insurance information will result in me being held personally liable. TKS Nutrition, LLC will file your insurance claim as long as TKS Nutrition, LLC is a provider under your insurance plan. I hereby authorize payment directly to TKS Nutrition, LLC for the services.

I hereby agree to be responsible to TKS Nutrition, LLC and to the dietitians providing medical nutrition therapy services for any and all charges that are incurred during my consultation and/or treatment and not paid or otherwise satisfied by insurance or other third party benefits. I am also responsible for:

- Co-pays are due at the beginning of the appointment. **We do not bill for co-pays.**
- We require **24 hour business day notice** to cancel and/or change appointments or a $50.00 fee will be charged to you or an appointment will be deducted from your self-pay package.
- Any appointment missed you will be charged a $50.00 fee or an appointment will be deducted from your self-pay package.
- There is a **$25** fee for any returned checks. **All payments for a returned check and further payments will be due in cash or money order only.**
- If your account is 90 days past due, it will be sent to a collection agency. A **$20 collections fee** will be issued on top of account balance.

In the event that I fail to pay in full for such charges within fifteen (15) days of demand by TKS Nutrition, LLC, I shall be obligated to pay reasonable and necessary costs, including the reasonable legal fees, and collection expenses, incurred by TKS Nutrition, LLC in pursuing its claim for payment. I acknowledge that TKS Nutrition, LLC may take all necessary steps to collect the debt which may include the use of outside services, such as, collection agencies, attorneys, etc.

Where Medicare benefits are applicable, I certify that the information given by me in applying for payment under Title VIII of the Social Security Act is correct. I assign and request payment of authorized Medicare benefits to TKS Nutrition, LLC and to the dietitians providing medical nutrition therapy service on my behalf for any services furnished to me. I authorize any holder of medical or other information about me to release to Medicare and its agents any information needed to determine the benefits for related services.

I have read this financial policy and understand my financial obligation.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) PRIVACY PRACTICES

I hereby acknowledge that I have received a copy of TKS Nutrition, LLC Notice of Privacy Practices.
I hereby acknowledge that I have read, understand, received a copy and agree to these policies.

DATE: ________ SIGNATURE: ______________________________________ Relationship: __________

PRINT NAME: ______________________________________ DOB:________________

DATE: ________ WITNESS: ____