Patient Information

Patient Last Name: Name:
Address:
City:
State:
Zip Code:
Date of Birth:
Age:
Sex: ○ female ○ male
Phone #:
Cell Phone :
Will you accept text confirmations? Yes ○ No ○
If yes, provide your phone carrier:
Email address:

Employment Information

Patient's or parent employer: enter employer here
Address:
City: State: Zip code:
Phone:
Spouse's employer
City: State: Zip Code:
Phone:

Payment Information .

Private Pay: ☐

Insurance Information (HMO/PPO's are ONLY accepted as form of payment if prior authorization/ referral provided):
Insurance Company:
Social Security #: **ID#:**
Group #: **Authorization #:**

Health Information

Reason for visit:
Medications:
Referring Health Care Provider:
Address: **Date of service:**

Please sign the back of the form in the presence of your health provider and attach insurance card, referral, and driver's license. Thank you. This form created by L.Beseler Business Consultants Revised 7/14

Authorization for Medical Information Release and Medical Treatment

1. I authorize nutritional care as necessary to the care of previously named individual.

2. I authorize any holder of medical or other information about me to release to the Social Security Administration, its intermediates, or carriers any information needed for insurance claim filing. I permit this authorization signature to remain on the chart and be used in place of the original and request payment of medical insurance benefits either to myself or to the party who accepts assignments.
3. I acknowledge full responsibility for payment of services rendered and agree to pay for them in full at the time of service unless other arrangements have been made in advance with this office. . If you refuse to pay your account will be turned over to an collection agency and a 35% fee will be charged to the account.
4. I understand that if I do not show up for a scheduled appointment without advance notice of 48 hours, I will be assessed and pay an office visit cancellation fee, regardless of any insurance coverage I may have.
5. I understand and agree that if I do not present current and proper insurance information at the time of check-in for each and every office visit, or if my health insurance is deemed terminated by the carrier, I will be responsible and agree to pay for any and all services rendered. If you refuse to pay your account will be turned over to an collection agency and a 35% fee will be charged to the account.
6. I agree that I will be responsible for all costs incurred in the collection of this debt should that be necessary.

_____

Patient/ Parent/Guardian Date

I HAVE RECEIVED A COPY OF THE PRIVACY ACT FROM THE FAMILY NUTRITION CENTER.

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Patient/ Parent/Guardian Date

Our Appointment policy- We know your time is valuable and we pride ourselves on keeping wait times to a minimum. Please help us maintain this standard by arriving 10-15 minutes early to fill out any necessary paperwork, as your appointment will start promptly at your scheduled time. Sometimes our patients are late due to traffic, etc. While we are sympathetic we cannot, in fairness to everyone else, "jam" late patients into the schedule. **If you are late your appointment will need to be rescheduled with a cancellation fee imposed**. Our office does not like to take this action but our appointments are structured to allow extensive individual time with our health professionals. Calling in late does not change the policy, the fee below will still apply.

Once you have made your appointment, we ask that you please give us 48 hours notice to cancel or reschedule to avoid a fee of $25.00. If you are scheduled for a **PRIME TIME** appointment a rescheduling fee of $50.00 will be charged with less than 48 hours notice. Our office does not like to collect rescheduling fees so please call us within the required time. (**Prime time 8AM, 8:30AM, 4:00, 4:30, 5:00, 5:30).**We also ask that if your next visit requires a prescription, referral, or authorization number, please make sure you get this from your Physician so you have it for your visit. Your insurance company will not allow us to see you with out the proper documentation.

Thank you and we look forward to helping you achieve all of your health and nutrition goals.

I have read and agree to the terms listed above.

_____ _____

Patient/Parent Signature Date