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PATIENT REGISTATION FORM

Patient's Name: _____ Date: _____

Date of Birth: _____

Mailing Address: _____

City: _____ State: _____ Zip Code:

_____

Primary Phone: _____ Cell Phone: _____

Email Address: _____

Marital Status: _____

Occupation: _____ Hours Worked: _____

Referring Physician: _____

Other Physicians: _____

Guardian's Name (if patient is younger than 18 years old)

_____

Reason for today's visit: _____

Insurance Company: _____ Insurance # _____

Social Security # _____

Please supply insurance card and ID for copies

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided the Nutrition Specialists, LLC Notice of Privacy Practices ("Notice"):

- It tells me how Nutrition Specialists, LLC will use my health information for the purposes of my treatment, payment for my treatment, and Nutrition Specialists, LLC's health care operations.
- The Notice also explains in more detail how Nutrition Specialists, LLC may use and share my health information for other than treatment, payment, and health care operations.
- Nutrition Specialists, LLC will also use and share my health information as required/permitted by law.

Print Patient's Legal Name: _____

Signature _____
(patient or legal authorized representative)

Date:_____

Relationship of authorized representative to patient: _____

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CONSENT FOR TREATMENT and PAYMENT POLICIES

The following information is to be completed by the patient or the patient's legally authorized representative/parent:

I consent to medical treatment for myself or for the patient for whom I am the parent or Legally Authorized Representative. I understand that Nutrition Specialists, LLC will share patient health information according to federal and state law for treatment, payment, and operations. I agree that Nutrition Specialists, LLC can have correspondence, request records, and send updates/notes with my doctors listed on registration form.

Nutrition Specialists is in Network with Medicare, Medicaid, United, Blue Cross Blue Shield PPO, SoonerCare, Health Choice, Healthcare Highway, Aetna, and Cigna. We are not in network with HMO policies, this requires a Prior Authorization which is the patient/guardian's responsibility.

I understand that the patient is responsible for all charges incurred, regardless of the patient's insurance status. The patient agrees to pay for services as the patient incurs the charges. I authorized Nutrition Specialists, LLC to file insurance claims, including Medicare, on my behalf and I authorize the insurance provider to pay Nutrition Specialists, LLC for services rendered. Overdue balances greater than 60 days are subject to be turned to a collection agency.

Visit Fees: Nutrition Specialist, LLC fees will be billed according to the insurance payment schedule. In event of self-pay it will match the insurance discounted rate. Medical Nutrition Therapy will be charged at $50/15-minute unit.

Cancellation Policy: Nutrition Specialist, LLC requires 24-hour notice of any change or cancellation of an appointment. Failure to give 24 hour notice will result in a $50 charge to the card on file at the conclusion of the missed appointment. If no valid credit card on file, the charge will be sent out within the week. If not paid within 30 days, the amount will be *sent to collections*.

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___ Telehealth or phone consultations: When you elect to see a dietitian by phone or telehealth the charge for your visit will be self pay. Nutrition Specialists cannot bill insurance for any visit or time that is not face to face with patient. Insurance requires that the patient be at a rural health clinic to qualify for telehealth coverage.

*** Medicare, Medicaid, and several insurances are making a 90-day exception for telehealth services during Pandemic from March 6 2020-June 6 2020. To guarantee coverage call you member benefits number for confirmation of this exception. Nutrition Specialists will bill for all telehealth services during this time, but can not guarantee coverage.

____ I authorize Nutrition Specialists, LLC to leave messages and appointment reminders on my phone or e-mail address.

Signature of Patient / Legally Authorized Representative: _____ Date: _____

Relationship of Legally Authorized Representative to Patient: _____

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CREDIT CARD on FILE

Nutrition Specialists keeps a card on file for patients as a form of convenience and to ensure that all balances are payed in a timely manner and to avoid sending balances to debt collectors. **Your card will only be charged for Cancellation fees, cost of telehealth visits, and on balances overdue for 60 days or longer.** You may contact Nutrition Specialists at any time to change your payment method or to set up a payment schedule. Please present card for verification along with this form.

Patient's Name: _____
Name as it appears on credit card:_____

Type of credit card: Mastercard Visa Discover Amex

Card number:
☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐

CVV:
☐☐☐

Expiration date: ☐☐/☐☐

Billing Zip Code: _____

I, _____, authorize Nutrition Specialists, LLC to process the above credit card as "Card on File". I understand that this authorization will remain in effect until the

NUTRITION SPECIALISTS

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expiration on the credit card account. Patient may also revoke this form by submitting a written request to the practice.

_____ _____

Cardholder's Signature/ Date