Welcome to Our Office

Legal Name: _____ Home Phone: (___)_____
Last First MI
Address: _____ Work Phone: (___)_____

City: _____ State: ___ Zip: _____ Birth Date: _____

Employer: _____

Note: these fields are needed for filing an insurance claim, please provide answers in relation to what your insurance company has on file. Thank you:

Female: _____ Male: _____ Marital Status: _____

Subscriber's Name: _____ Home Phone: (___)_____
Last First MI

Address: _____ Work Phone: (___)_____

City: _____ State: ___ Zip: _____ Birth Date: _____

Employer: _____

Number of Insurance Plans that Cover You: _____

Primary Insurance Information: Secondary Insurance Information:

Subscriber Name: _____ Subscriber Name: _____

Insurance Company: _____ Insurance Company: _____

Does your insurance require a referral to see us? Yes _____ No _____

Emergency contact (not living with you): _____ Phone: (___)_____

Address: _____City/State:_____Zip:_____

I authorize any holder of medical or other information about me to release this information to the Center for Medicare and Medicaid Services, my insurance company or its intermediaries or carriers, or to this dietitian's office or my attorney or other doctor's office. I authorize direct payment of medical benefits to include major medical benefits to which I'm entitled, including Medicare, private insurance or any other health plan to Bay Area Nutrition, LLC. I also permit a copy of this authorization to be used in place or the original. This assignment will remain in effect until revoked by me in writing. As a courtesy we will assist you with billing your insurance company for insurance companies that contract with us. However, you are responsible for determining what your insurance will cover, whether you require a referral, and for the payment of your bill. I understand that I am financially responsible for all charges whether or not paid by said insurance.

Date: _____ Signature: _____

Please See Reverse Side

- ☐ **I understand that Bay Area Nutrition, LLC has a 24 hour cancellation policy. It is my responsibility to call the office at least 24 hours prior to my appointment to cancel or reschedule an appointment. If my appointment is scheduled for 10am on Friday, I must call prior to 10am the preceding Thursday to avoid being charged the full deposit fee of $ 145.00 or $165.00 (based upon my RDs rate).**

- ☐ **I understand that Bay Area Nutrition, LLC, as a courtesy, will submit claims for nutrition services to insurance companies that contract with Bay Area Nutrition, LLC.**

- ☐ **I understand that Bay Area Nutrition, LLC will submit claims for nutrition services to insurance companies that do not contracted with Bay Area Nutrition, LLC when clients have agreed to our fee structure agreement and are willing to pay a deposit for sessions.**

- ☐ **I understand that I am responsible for my bill including any co-pay or co-insurance or deductible as dictated by my insurance policy.**

- ☐ **I understand that Bay Area Nutrition, LLC requires me to keep a valid credit card on file and has my authorization to charge this credit card any balances, co-pay, co-insurance or deductible as dictated by my insurance policy.**

- ☐ **I agree to update Bay Area Nutrition, LLC with any changes to my credit card account and provide a new valid credit card as needed.**

- ☐ **If I am not insured, or my Insurance Company will not authorize or pay for this visit, I understand that I am responsible for my bill.**

- ☐ **I understand that if my account is overdue, Bay Area Nutrition, LLC will charge a $25 late fee monthly.**

- ☐ **I permit a copy of this authorization to be used in place of the original.**

_____ _____

Client's Name **Responsible Party's Name**

_____

Client's or Authorized Person's Signature

_____

DATE

Valid Credit Card Information Form

Client Name: _____ **Date of Birth:** _____

Card # _____ **PIN/CVV #** _____

Card Member: _____ **Exp. Date:** _____
(Name as it appears on Credit Card)

Billing Address for Card:

Street: _____

City: _____ **State:** _____ **Zip:** _____

_____ **I authorize Bay Area Nutrition, LLC to charge my credit card for any balances, co-pay, co-insurance or deductible as dictated by my insurance policy and Bay Area Nutrition, LLC's Fee Structure Agreement.**

_____ **I agree to update Bay Area Nutrition, LLC with any changes to my credit card and provide a new valid credit card as needed.**

Signature: _____ **Date:** _____

For Office Use Only

Authorization Date: _____ Authorization #: _____

Post Auth. Date: _____ Post Auth. #: _____

Updated: 4/19