Welcome to Our Office

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

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

Employer: _____ SS#: _____

Female: ___ Male: ___ Marital Status: _____

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

Address: _____ Work Phone: (___)_____

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

Employer: _____ SS#: _____

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 provide at least 24 hours notice in the event that I must cancel or reschedule an appointment. If I do not provide 24 hours notice I will be liable for the payment of my office visit fee of $ 120.00**

- **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 contract with Bay Area Nutrition, LLC when clients have agreed to our fee structure agreement and are willing to pay a deposit for sessios .**

- **I understand that I am responsible for my bill including any co-pay or co-insurance or deductible under my insurance policy.**

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

_____

Client's Name

_____

Client's or Authorized Person's Signature

_____

DATE