Nutrition Your Way LLC **Amanda Petty, MS, RD, LDN**

Patient Information

Name:_____ Date:_____ Gender:_____

Age: _____ Date of Birth: _____ SS#: _____

Address: _____

Cell Phone:_____ Work Phone:_____ Home Phone:_____

E-mail: _____

Indicate best way to contact you by circling

Physician: _____ Physician's Phone: _____

Reason for Appointment: _____

Employment Status: ___Full Time ___Part Time ___Not Employed

Occupation: _____ Place of Employment: _____

Education Level: ___Elementary ___High School ___College ___Graduate School

Marital Status: ___Single ___Married ___Divorced ___Separated ___Widowed

Number of Children:_____ Family Size: _____

Emergency Contact: Name_____ Relationship_____

Phone_____

Insurance Information:

Primary Insurance Provider: _____

Insurance Policy Number: _____

Insurance Policy Holder: _____ Date of Birth: _____

Relationship to policy holder: _____

Person responsible for account: _____

Secondary Insurance Information: _____

Acknowledgement of Receipt of Notice of Privacy Practices

Your name and signature on this sheet indicate that you have been given the opportunity to review and request a copy of the Nutrition Your Way LLC's Notice of Privacy Practices (Notice) on the date indicated. If you have any questions regarding the information in Nutrition Your Way's Notice of Privacy Practices, please do not hesitate to contact the representative (Amanda Petty, RD, LDN) as indicated on your Notice.

Patient Name (Printed): If Patient Representative, Name (Printed):

_____ _____

_____ _____

Signature Date Notice Received

Financial Responsibility

I, the undersigned, certify that I or my dependent, have insurance coverage with the above named provider and assign directly to Amanda Petty, MS, RD, LDN, doing business as Nutrition Your Way LLC, all insurance benefits for services provided to me. If any fees are not covered by insurance, I understand that I am financially responsible for all charges accumulated. If the insurance company fails to pay Nutrition Your Way LLC for any reason; then I understand that I will be responsible for prompt payment of all amounts owed to Nutrition Your Way LLC. I understand that the cost of an initial office visit is $140.00 and that follow up visits are $70.00. Should the account be referred to a collection agency or attorney for collection, the undersigned shall pay all costs of collection, including a reasonable attorney's fee.

Responsibility to Provide Proof of Insurance and Obtain Referral

I understand it is my responsibility to provide Nutrition Your Way LLC with a copy of my current insurance card and to obtain a referral from my Primary Care Physician for medically necessary nutrition assessment and intervention. If I do not have insurance, or my insurance does not include provision for nutrition services, I may be considered a Private Pay (or Self Pay) patient and I am financially responsible for the total amount of services provided, in which case a cash discount may be applied.

Additional Information

Nutrition Your Way LLC accepts payment in cash and check. I understand additional charges are applied to my account for returned checks used to pay on my account, for certified letters sent to me for collection on my account and a collection agency fee. I understand that Nutrition Your Way LLC requires at least twenty-four (24) hours notice for cancellation of any appointment. I understand if I fail to notify Nutrition Your Way LLC within this time frame, I may be charged the full amount of an office visit.

Assignment of Benefits

I hereby authorize and assign all payments and/or insurance benefits for nutrition services rendered to the patient directly to Nutrition Your Way LLC. I hereby authorize Nutrition Your Way LLC to release medical information necessary to obtain payment. I understand that I am responsible for all charges not covered by my insurance plan. In the event I receive payment from my insurance carrier, I agree to endorse any payment due for services rendered to Nutrition Your Way LLC. I authorize the use of this signature for all insurance claims submitted for medical nutrition therapy and related diagnostic procedures.

Signature

BY SIGNING THIS AGREEMENT, I ACKNOWLEDGE THAT I HAVE CAREFULLY READ, HAVE UNDERSTOOD AND AGREE TO THE ABOVE TERMS AND CONDITIONS.

_____ _____ _____

Signature of Patient, Guardian or Legal Representative Relationship Date