Nutrition Works! LLC Client Information

Client name: _____ Date of birth: _____

Mailing address (street/PO Box, town, zip): _____

Telephone number(s): _____

Health insurance plan: ☐ Cigna ☐ Anthem ☐ Harvard ☐ Aetna ☐ Medicare ☐ United HC ☐ Other: _____

Health insurance ID number: _____

Health insurance provider service telephone number: _____

If you are covered by another insurance plan, please provide the health plan name, ID number, and customer service telephone number: _____

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Appointments require a valid credit card number or other appropriate security in order to assure payment of any deductibles, copayments, charges or fees not covered by insurance. No amount will be charged to the card until such non-covered deductibles, copayments, charges or fees have been incurred.

Cancellation policy: We will gladly reschedule or cancel appointments with 48 hours notice without penalty. Appointments cancelled or missed without receipt of 48 hours advance notice will result in a cancellation charge of $75. This charge is not covered by insurance and is the client's sole responsibility.

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Everything discussed in sessions is confidential. If your doctor referred you, he/she may receive a report about your visit(s). If it is necessary to speak with someone else about your care, it will only be done with your agreement and written permission.

I was given an opportunity to read and keep a copy of Nutrition Works! LLC's Notice of Privacy Practices which describes how the practice handles and protects my confidential health information. Yes ☐ No ☑

I permit Nutrition Works! LLC to leave telephone messages for me at home/cell. Yes ☐ No ☑ Not applicable ☐

I permit Nutrition Works! LLC to communicate with me with text messages. Yes ☐ No ☑ Not applicable ☐

I permit Nutrition Works! LLC to leave telephone messages for me at work. Yes ☐ No ☑ Not applicable ☐

I understand that e-mail may not be very secure but I still permit Nutrition Works! LLC to communicate with me using e-mail. ☑ Yes ☐ No

E-mail address: _____

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I authorize the release of any medical or other information necessary to submit a claim to my health insurance company. I agree to pay Nutrition Works! LLC for services rendered in the event that my insurance company does not cover them.

I agree to the terms and conditions expressed herein.

Signed _____ Date _____

Credit Card Information

Appointments require a valid credit card number or other appropriate security in order to assure payment of any deductibles, copayments or charges or fees for agreed to services not covered by your insurance. No amount will be charged to the card until such non-covered deductibles, copayments, cost shares, charges or fees have been incurred.

Your credit card information or other appropriate security will be stored in a locked box, separate from your other records, while you are a client at Nutrition Works LLC. It will be shredded when all of your deductibles, copayments or charges or fees for agreed to services not covered by your insurance have been paid and you are no longer a client at Nutrition Works LLC.

Client name: _____ Card holder name: _____

☑ MasterCard ☐ Visa ☐ Discover ☐ American Express

Card number:_____

Card expiration date: _____ 3 digit card security code: _____ Billing zip code: _____

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