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 □ Tufts

Other: ___________________________

Health insurance ID number: ____

Health insurance provider customer 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 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.

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.

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 work. □ **Yes** □ **No**

I permit Nutrition Works! LLC to leave telephone messages for me at home. □ **Yes** □ **No**

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:** ____

Nutrition Works! LLC sends out an e-mail newsletter 2-4 times a year. It includes a recipe, interesting nutrition updates, and information about food and nutrition related things going on in our community. Would you like to receive this?

□ **Yes** □ **No thanks**

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 understand and 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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