CLIENT REGISTRATION

Date: _____

Name: _____ DOB: _____
Address:_____ City: _____
State: _____ Zip: _____ Home Phone: _____ Email: _____
SS#_____ How did you hear about us? _____

Please list all current health concerns:
_____
_____
_____

Please list any/all previous health concerns (within last 10 years):
_____
_____

Primary Physician: _____ Practice: _____
Address: _____ Phone: _____ Fax: _____

I authorize the release of verbal and/or written information between Lifestyle Management & Nutrition and the above named physician/medical group: _____

Date: _____ _____
Signature

Secondary Physician / Specialist: _____ Practice: _____
Address: _____ Phone: _____ Fax: _____

I authorize the release of verbal and/or written information between Lifestyle Management & Nutrition and the above named physician/medical group: _____

Date: _____ _____
Signature

Therapist / Specialist or Other: _____ Practice: _____
Address: _____ Phone: _____ Fax: _____

I authorize the release of verbal and/or written information between Lifestyle Management & Nutrition and the above named physician/medical group: _____

Date: _____ _____
Signature

(Yearly Information Review)
The above information remains an accurate representation of my demographic information. I remain aware that I am responsible to provide LMN with changes to this information, when applicable.
Signature: _____ Date: _____

INSURANCE POLICY

We at Lifestyle Management & Nutrition are committed to providing you with the best care possible. If you have medical insurance, we are pleased to help you receive your maximum allowable benefits. However, we must emphasize that our relationship is with you, not with your insurance company. We are not a party to that contract except where we are contracted as preferred providers.

While the filing of your insurance claim is a courtesy that we extend to our clients, all charges are strictly your responsibility from the date(s) service was rendered. Therefore, it is often necessary for you to inquire and explore your benefits with your insurance carrier. We realize that temporary financial problems may affect timely payment of your account. If such problems arise, we encourage you to contact us promptly for assistance in helping manage your account.

We will gladly file your claim(s) for the following insurance companies:

BLUE CROSS BLUE SHIELD OF VERMONT*
MVP HEALTHCARE*
VERMONT MANAGED CARE*

*Lifestyle Management & Nutrition will gladly submit any claim with other insurance companies, other than those noted, should you present us with your benefit limits in writing at or prior to your scheduled date of service.

Prior to filing *any* insurance claim we must have a record of your treatment diagnosis on file and/or some insurance plans may require a referral. The ability to diagnose any condition is not within the scope of practice for a registered dietitian and must be obtained from your physician. If our office does not receive the appropriate documentation of your medical condition or referral at or prior to your scheduled session, you will be responsible for payment in full at the time services are rendered.

Also, a referral to our office does not always guarantee coverage. We always recommend that you check your coverage limits for these services prior to your scheduled session – despite any recommendations for these services from your physician.

All payment, including co-payment, is due at the time services are rendered. We accept cash or check. Any and all outstanding balances and/or insurance claim denials are payable within 30 days of invoice. Any balance which reaches more than 90 days past due will be sent through our collection process. If your balance is sent for collection, your initials acknowledge that you will be responsible for all collection fees, as well as any legal fees that our office incurs in order to collect the outstanding delinquent balance.

By my signature below I acknowledge the above financial policy and agree to its terms.

Signature: _____ Date: _____

INSURANCE INFORMATION PAYMENT & FINANCIAL INFORMATION

Who is financially responsible for this account?

Name: _____ DOB:_____
Relation: _____ SS#: _____
Address: _____
Phone: _____

By my signature below I acknowledge:

All payment, including co-payment, is due at the time services are rendered.

We accept cash or checks payable to Lifestyle Nutrition.

A **$ 20.00 fee** is applied for all appointments that are not cancelled within 24 hours of your scheduled date/time of session. **Initials: _____**

Any and all outstanding balances and/or insurance claim denials are payable within 30 days of invoice.

I will have a late charge of 10% added to my balance if unpaid after 30 days.

Any balance reaching more than 60 days past due will be sent through our collection process.

If your balance is sent for collection, you acknowledge that you will be responsible for all collection fees, as well as any legal fees that our office incurs in order to collect the outstanding delinquent balance.

There is a **$ 25.00 fee** for a returned check**. Initials: _____**

All nutrition packages are non-refundable but may be transferable to other services rendered by Lifestyle Management & Nutrition and/or products. All packages expire 1 year after date of purchase.

SIGNATURE: _____
DATE: _____

The above information remains an accurate representation of my financial information. I am aware of my responsibility to provide LMN with any changes in writing when appropriate.

INSURANCE INFORMATION

Primary Insurance:
Name of insured: _____ DOB: _____
Relationship: _____

Insurance Company: _____ Phone#: _____
Address: _____
ID#: _____ Policy#: _____ Group#: _____

Employer's Name_____
Employer's Address: _____ Phone#: _____

Secondary Insurance:
Name of insured: _____ DOB: _____
Relationship: _____
Insurance Company: _____ Phone#: _____
Address: _____
ID#: _____ Policy#: _____ Group#: _____
Employer's Name_____
Employer's Address: _____ Phone#: _____

Assignment of Insurance Benefits

I, the undersigned, have insurance coverage with _____ and assign directly to ***Lifestyle Management & Nutrition*** (LMN) all medical benefits, if any, otherwise payable to me for services rendered. I hereby authorize ***LMN*** to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

Signature of Insured/Guardian: _____ Date: _____

(Yearly Information Review) The above information remains an accurate representation of my financial information. I am aware of my responsibility to provide LMN with any changes in writing when appropriate.

Signature: _____ Date: _____

HIPAA Patient Communication Form

NAME: _____ **DOB**: _____

As a patient in our practice, from time to time we may need to communicate with you when you are not in the office. To preserve your privacy, we would like for you to indicate your preferred method for us to communicate medical information to you, and to others involved in your care, if needed. Examples of medical information include appointment reminders and nutrition plan information.

Without specific permission we will not release any of your medical/nutrition information to another person. In some cases you may wish for another persona to have access to your medical information. Please identify those individual(s) and their relationship to you (i.e. spouse, parent, son, daughter, etc)

NAME / RELATIONSHIP

_____ _____

_____ _____

In the event that no one is available to answer your phone, we need permission to leave certain types of information on your answering machine/voicemail. Please indicate your preference by checking one of the spaces below:

( ) Do not leave any medical information on my answering machine or voice mail. In this event you will only be asked for a return call to receive further information.

( ) I give Lifestyle Management & Nutrition personnel permission to leave medical Information pertaining to me on my answering machine or voice mail at the number(s) listed below:

PHONE NUMBERS

Home: _____

Work: _____

Cell: _____

I assume responsibility to inform Lifestyle Management & Nutrition of changes in my phone number (s) or my preference for information release. I also acknowledge that I have received and/or read a copy of Lifestyle Management & Nutrition's privacy practices.

PRINTED NAME: _____

SIGNATURE: _____