



CLIENT REGISTRATION

Date: _____

Name: _____ DOB: _____

Address: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Email: _____

SS# _____ Do you wish to receive our e-news announcements? Y N

How did you hear about us?

- Advantage Nutrition Mailer
- Doctor (please specify) _____
- E-Mail
- E-News
- Friend/Relative
- Work
- In Office Promotion
- Insurance Company
- Internet
- Natural Awakening
- Market Place
- Other (please specify) _____

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 Advantage Nutrition & Wellness, LLC 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 Advantage Nutrition & Wellness, LLC 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 Advantage Nutrition & Wellness, LLC 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 ANW with changes to this information, when applicable.

Signature: _____ **Date:** _____



INSURANCE POLICY

We at Advantage Nutrition & Wellness, LLC 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:

AETNA* CIGNA* Highmark Independence BC Keystone HP East

DEVON* Medicare* Capital BC* Keystone HP Central*

*ANW will only submit claims to the above noted insurance companies for particular diagnoses. Please speak with our office staff and/or your provider for additional details.

We 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, check, MasterCard, Visa, AMEX, or Discover. 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:** _____



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, check, MasterCard, Visa, AMEX, or Discover.
- A **\$ 30.00 fee** is applied for all appointments that are not cancelled within 24 business 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 in-house services or products. All packages expire 1 year after date of purchase.

SIGNATURE: _____

DATE: _____

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

Signature: _____ **Date:** _____
_____ **Date:** _____



INSURANCE INFORMATION

Primary Insurance:

Policy Holder Name: _____ DOB: _____

Relationship: _____

Insurance Company: _____ Phone#: _____

Address: _____

ID#: _____ Policy#: _____ Group#: _____

Employer's Name _____

Employer's Address: _____ Phone#: _____

Secondary Insurance:

Policy Holder Name: _____ 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 **ADVANTAGE NUTRITION & WELLNESS, LLC** (ANW,LLC) all medical benefits, if any, otherwise payable to me for services rendered.
- I hereby authorize **ANW, LLC** 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 ANW with any changes in writing when appropriate.

Signature: _____ **Date:** _____

_____ **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 person 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 Advantage Nutrition & Wellness personnel permission to leave medical Information pertaining to me on my answering machine or voice mail at the number(s) Listed below:

PHONE NUMBER

Home: _____

Work: _____

Cell: _____

I assume responsibility to inform Advantage Nutrition & Wellness, LLC 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 Advantage Nutrition & Wellness's privacy practices.

NAME: _____

SIGNATURE: _____ **DATE:** _____