NUTRIHEALTH
WELLNESS • NUTRITION • FITNESS

Phone: 302-202-3438 Fax: 302-856-1868

**Patient Name:** (First, Middle Initial, Last) _____

**Social Security Number**: _____**Birth Date (MM/DD/YYYY):** _____ **Gender**:_____

**Address**: _____

City State Zip

**Daytime Phone**: _____ **Home Phone**: _____ **Cell Phone**: _____

**E-mail:** _____ **Marital Status:** Married Single Divorced Widowed

**Employer Name:**_____ **Employer Phone:** _____

**Employer Address:** _____

City State Zip

**Race:** American Indian/Alaska Native Asian Black White Native Hawaiian/Pacific Islander Other

**Ethnicity:** Hispanic or Latino Not Hispanic or Latino Preferred Language Spoken _____

**Minor Patient:** Patient resides/lives with? Name: _____ **Relationship:**_____

**Preferred Pharmacy:** _____ **Address of Pharmacy:** _____

**Were you referred by a physician? If so, who?** _____

**No? How did you hear about us?** _____

**Primary Care Provider**_____

**Responsible Party** (for example "Self" or give details of parent, guardian, or other person responsible for consent and payment:

**Name:** _____ **Relationship to Patient**:_____

**Social Security Number:** _____ **Date of Birth (MM/DD/YYYY):** _____

**Employer Name:** _____ **Employer Phone:** _____

**Employer Address:** _____

**Emergency Contact:** (A person we may contact if an emergency arises while in the office

**Name**: _____ **Relationship to Patient**:_____

**Phone**:_____ **Alt Phone**: _____

**Does the patient have insurance? Yes / No (if yes, please present your card(s) so copies may be made.)**

**Primary Insurance:**_____ **Policy Holder:** _____

**Subscriber ID#:** _____ **Group#:** _____

**Claims Address:** _____

**Policy Holder's SSN:** _____ **Policy Holder's Birth Date:** _____

**Secondary Insurance:** _____ **Policy Holder:** _____

**Subscriber ID#:** _____ **Group#:** _____

**Policy Holder's SSN:**_____ **Policy Holder's Birth Date:**_____

**Confidentiality Information**

Confidentiality laws state that no medical information regarding diagnosis, or treatments/treatment plans may be released to any other person(s) without the written consent of the patient (or guardian if applicable). Please provide us with the names and phone numbers of any people with whom you wish for us t be able to discuss your medical/account information with, such as spouse, family members or friends:

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

**Consent to treat a minor:** By law, minors must be accompanied by a parent or guardian. If a parent or guardian is unable to accompany your minor, we must have a signed release on file. Please list below the name(s) of the person(s) you wish to give permission to accompany your minor to their visits as well as to consent to any necessary examination and/or treatment to be rendered under the supervision of the Doctor or Nurse Practitioner who is licensed to practice in Delaware. This consent will expire in one year. After one year, you will be asked to fill out a separate minor consent form.

Name:_____ Relationship:_____ Phone:_____

Name:_____ Relationship:_____ Phone:_____

**Financial Responsibility Statement/Release of Information**

I hereby authorize treatment and authorize Nutrihealth, LLC to release information for these services to my insurance carrier for payment. I further authorize that payment of benefits be made to the provider on my behalf. I hereby authorize Nutrihealth, LLC to obtain or release any and all pertinent information regarding my medical care, as needed, to assist in my ongoing treatment to or from other health care providers, laboratories, radiology facilities or other institutions.I authorized you to use and disclose my contact information to your internal staff for the purpose of marketing communications or promotions pertinent to me.
This authorization remains in effect until revoked.

_____ _____

Signature of Patient/Guardian Date

# NUTRIHEALTH, LLC FINANCIAL POLICY

**Insurance:** Although we are contracted with several insurance companies, it is your responsibility to make sure that our office is a contracted provider in your plan. It is also your responsibility to know your insurance benefits.

As a courtesy to our patients, we will file insurance claims from our office. This may include consultations, follow-up appointments, testing, etc. In order to do this, we will require information from you. We will need all your demographic information prior to your appointment. We also request an update of this information every year (the beginning of the year) thereafter. We ask that at the time of your appointment you bring in your ID and insurance card, as well as any other information that will assist in making sure your claim is filed correctly.

At the time of service, and if applicable, you will be responsible for all fees that are not covered by your insurance, including co-payment, co-insurance, deductible, and non-covered services or items received. The co-payment, co-insurance and deductible cannot be waived by our practice, as it is a requirement placed on you by your insurance carrier. We strive to be as accurate as possible in calculating your responsibility, but with some many variations in policies and fee schedules, we are not always exact. You may receive a statement from our office for any balance due. If you do not have insurance, payment is expected at the time of service. If you are unable to pay, you will need to make prior arrangements with the practice administrator. You may also apply for a discount at the front desk. For your convenience, we accept cash, checks, credit cards (Visa, Mastercard) and money orders. Payments are also accepted over the phone.

**Statement to Permit Payment of Medicare Benefits:** I request payment of authorized Medicare benefits on my behalf for any services furnished by Nutrihealth, LLC. I authorize any holder of medical and other information about me to release to Medicare and its agents any information needed to determine these benefits for related services.

**Billing:** If you receive a bill from our office, it is because your insurance company has stated the balance is your responsibility. Please contact our billing department if you have any questions concerning your bill. If you cannot pay the balance in full, please call our office to make affordable payment arrangements.

**No-Show, Returned Check, Insufficient Funds Fees:** There will be a $50 no-show fee for any missed scheduled appointments. If an insufficient funds check is presented for payment, you will be charged a $25 fee and checks will no longer be accepted.

**Collections:** Accounts that are not paid in full within 45 days begin our in-house collection process. If your balance becomes 120 days old, your doctor will be notified and you may be subject to further collection activity from an outside collection agency.

**Acknowledgement:** I acknowledge that I have read and understand the financial policy of Nutrihealth, LLC

**Signature of Patient/Guardian** **Date** **Witness (Office use only)**

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# Telehealth Safety Consent

We are pleased to offer telehealth services to patients in order to improve access and availability. To ensure confidentiality and safety, we ask patients that utilize telehealth visits to adhere to the following guidelines:

1. Please arrange to be in a confidential location at the time of your telehealth visit.
2. To maintain patient safety, we WILL NOT provide telehealth services to a patient while they are driving.

_____
Patient name

_____
Patient Signature

_____
Date

- We offer telehealth via FaceTime, Google Duo or Zoom.
- Please provide an accurate mobile number.
- In order to provide comprehensive care, please measure your weight on the morning before your telehealth appointment. Your weight measurements are required.