

**Welcome to Our Office**

Legal Name: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_  
                   Last                  First                  MI  
 Address: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
 Employer: \_\_\_\_\_

**Note: these fields are needed for filing an insurance claim, please provide answers in relation to what your insurance company has on file. Thank you:**

Female: \_\_\_\_\_ Male: \_\_\_\_\_ Marital Status: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Home Phone: (\_\_\_\_) \_\_\_\_\_  
                   Last                  First                  MI  
 Address: \_\_\_\_\_ Work Phone: (\_\_\_\_) \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_ Zip: \_\_\_\_\_ Birth Date: \_\_\_\_\_  
 Employer: \_\_\_\_\_

Number of Insurance Plans that Cover You: \_\_\_\_\_

Primary Insurance Information:

Secondary Insurance Information:

Subscriber Name: \_\_\_\_\_ Subscriber Name: \_\_\_\_\_

Insurance Company: \_\_\_\_\_ Insurance Company: \_\_\_\_\_

Does your insurance require a referral to see us? Yes \_\_\_\_\_ No \_\_\_\_\_

Emergency contact (not living with you): \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ City/State: \_\_\_\_\_ Zip: \_\_\_\_\_

I authorize any holder of medical or other information about me to release this information to the Center for Medicare and Medicaid Services, my insurance company or its intermediaries or carriers, or to this dietitian's office or my attorney or other doctor's office. I authorize direct payment of medical benefits to include major medical benefits to which I'm entitled, including Medicare, private insurance or any other health plan to Bay Area Nutrition, LLC. I also permit a copy of this authorization to be used in place of the original. This assignment will remain in effect until revoked by me in writing. As a courtesy we will assist you with billing your insurance company for insurance companies that contract with us. However, you are responsible for determining what your insurance will cover, whether you require a referral, and for the payment of your bill. I understand that I am financially responsible for all charges whether or not paid by said insurance.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

**Please See Reverse Side**

- I understand that Bay Area Nutrition, LLC has a **48 hour** cancellation policy. It is my responsibility to call the office at least **48 hours** prior to my appointment to cancel or reschedule an appointment. If my appointment is scheduled for 10am on Friday, I must call prior to 10am the preceding Wednesday to avoid being charged the full deposit fee of **\$ 155.00 or \$175.00** (based upon my RDs rate).
- I understand that Bay Area Nutrition, LLC, as a courtesy, will submit claims for nutrition services to insurance companies that contract with Bay Area Nutrition, LLC.
- I understand that Bay Area Nutrition, LLC will submit claims for nutrition services to insurance companies that do not contracted with Bay Area Nutrition, LLC when clients have agreed to our fee structure agreement and are willing to pay a deposit for sessions.
- I understand that I am responsible for my bill including any co-pay or co-insurance or deductible as dictated by my insurance policy.
- I understand that Bay Area Nutrition, LLC requires me to keep a valid credit card on file and has my authorization to charge this credit card any balances, co-pay, co-insurance or deductible as dictated by my insurance policy.
- I agree to update Bay Area Nutrition, LLC with any changes to my credit card account and provide a new valid credit card as needed.
- If I am not insured, or my Insurance Company will not authorize or pay for this visit, I understand that I am responsible for my bill.
- I understand that if my account is overdue, Bay Area Nutrition, LLC will charge a \$25 late fee monthly.
- I permit a copy of this authorization to be used in place of the original.

\_\_\_\_\_  
Client's Name

\_\_\_\_\_  
Responsible Party's Name

\_\_\_\_\_  
Client's or Authorized Person's Signature

\_\_\_\_\_  
DATE

## **Valid Credit Card Information Form**

**Client Name:** \_\_\_\_\_ **Date of Birth:** \_\_\_\_\_

**Card #** \_\_\_\_\_ **PIN/CVV #** \_\_\_\_\_

**Card Member:** \_\_\_\_\_ **Exp. Date:** \_\_\_\_\_  
*(Name as it appears on Credit Card)*

**Billing Address for Card:**

**Street:** \_\_\_\_\_

**City:** \_\_\_\_\_ **State:** \_\_\_\_\_ **Zip:** \_\_\_\_\_

\_\_\_\_\_ **I authorize Bay Area Nutrition, LLC to charge my credit card for any balances, late cancellations, co-pay, co-insurance or deductible as dictated by my insurance policy and Bay Area Nutrition, LLC's Fee Structure Agreement.**

\_\_\_\_\_ **I agree to update Bay Area Nutrition, LLC with any changes to my credit card and provide a new valid credit card as needed.**

**Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

***For Office Use Only***

**Authorization Date:** \_\_\_\_\_ **Authorization #:** \_\_\_\_\_

**Post Auth. Date:** \_\_\_\_\_ **Post Auth. #:** \_\_\_\_\_