Urban Nutrition, LLC
Life is hectic, eating healthy shouldn't be.

OFFICE POLICIES

Financial Disclosure & Disclaimer

In order to meet your needs and provide you with the best possible care, the following office policies are established:

Confidentiality

All sessions are held in strict confidence. In order to improve the quality of your care, a release form is obtained to permit coordination with your care with your physician or psychotherapist.

Session Duration

Initial evaluations are 45-60 minutes. Follow-up sessions are 30 - 45 minutes. We will do our best to begin our sessions on time and appreciate your cooperation in ending them on time. Please respect your Dietitian's appointment time limits.

Billing and Insurance Coverage

Payment is required at the time of your session in the form of cash, check or credit card. Please make checks payable to **Urban Nutrition, LLC**. Medical insurance companies may or may not offer coverage for outpatient nutrition counseling. If your insurance company does not, be sure to request this benefit. If you would like, we will prepare a separate bill for you so that you may submit it to your insurance company. A letter from your physician referring you to see a dietitian with the stated diagnoses may improve your chances of obtaining coverage. We will file claims for those plans we participate in and will require you to pay for your copay, deductible/coinsurance at the time of the visit. Please be advised if we have not heard from your insurance company within 60 days, the balance will become the patient's responsibility and we will send you an invoice for the balance. If this balance is not paid in full within 60 days from the time of receipt, your credit card will be charged for the full balance of the invoice in question. Any check returned due to insufficient funds will result in a fee of $25.00 per check.

Cancelation Policy

Please record the date and time of your appointment. Reminder calls may be given prior to your scheduled appointment, but please keep in mind that reminder calls are a courtesy and that you will be charged a **$25 fee if you miss your appointment or if you do not cancel your appointment at least 24 hours in advance.** Certain exclusions may apply.

I understand that I am responsible for payments of all charges resulting from this visit or future visits. I have read this financial policy and understand that I am responsible for payment of services provided by Urban Nutrition, LLC.

_____	_____	_____
PRINTED PATIENT NAME	**SIGNATURE OF PATIENT/GUARDIAN**	**DATE**

Urban Nutrition, LLC
Info@MyUrbanNutrition.com
MyUrbanNutrition.com

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Patient Registration Form

Please complete and sign a **Patient Registration Form** prior to your visit.

Patient Name: _____ DOB: _____/_____/_____Age: _____

Home Address: _____ City_____ Zip: _____

Home Phone: (_____)_____ Work Phone: (_____)_____

Cell Phone: (_____)_____ E-mail address: _____

Patient's SS#: _____ Driver's License #: _____

Employer: _____ Occupation: _____

Reason for Referral: _____

Name of Person Responsible for Payment: _____

Address: _____

Home Phone: (_____)_____ Work Phone: (_____)_____

Cell Phone: (_____)_____ E-mail address: _____

Credit Card Number: _____ Expiration date: _____

Name on credit card:_____ CVV: _____

I HEREBY,

1) **CERTIFY THAT I AM FINANCIALLY RESPONSIBLE FOR ALL SERVICES RENDERED TO ME AND/OR MEMBERS OF MY FAMILY.**
2) **CERTIFY THAT I HAVE RECEIVED AND AGREE TO THE PRACTICE POLICIES.**
3) **CERTIFY THAT I HAVE RECEIVED A COPY THE URBAN NUTRITION, LLC HIPAA PRIVACY NOTICE.**

_____ _____

SIGNATURE OF PATIENT/GUARDIAN **DATE**

Urban Nutrition, LLC
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Patient Insurance/Contact Information

Primary Insurance Information

Name of Insurance Company: _____

Provider Customer Svc #: (_____)_____ Benefits/Claims #: (_____) _____

Claims Address listed on Insurance Card: _____

ID # (member #): _____ Group or Plan #: _____

Insured Party's Name: _____ Relationship to patient: _____

Insured Party's Date of Birth: _____ Insured Party's SS#: _____

Insured Party's Employer: _____ Insured Party's phone # _____

Secondary Insurance Information

Name of Insurance Company: _____

Provider Customer Svc #: (_____)_____ Benefits/Claims #: (_____) _____

Claims Address listed on Insurance Card: _____

ID # (member #): _____ Group or Plan #: _____

Insured Party's Name: _____ Relationship to patient: _____

Insured Party's Date of Birth: _____ Insured Party's SS#: _____

Insured Party's Employer: _____ Insured Party's phone # _____

Emergency Contact Information: I hereby give permission to Urban Nutrition, LLC to disclose and discuss any information related to my medical condition to/with the following:

Emergency Contact: _____ Relationship to patient: _____

Home #: (_____)_____ Alternate phone #: (_____)_____

Preferred Personal Communication:

E-mail: _____
☐ Ok to email with detailed information ☐ Email with appointment reminder only.

Cell Phone:_____
☐ Ok to leave message with detailed information ☐ Leave message with call back number only.

Alternate Phone:_____
☐ Ok to leave message with detailed information ☐ Leave message with call back number only.

The duration of this authorization is indefinite unless otherwise indicated in writing. I understand that requests for medical information from persons not listed above will require a specific authorization prior to the disclosure of any medical information.

_____ _____

SIGNATURE OF PATIENT/GUARDIAN **DATE**

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CONSENT FOR TREATMENT AND AUTHORIZATION FORM FOR USE OF PROTECTED HEALTH INFORMATION

Patient Name: _____ DOB: _____

Parent/Guardian: _____ (Applies only to patients under 18)

I herby consent to participating in nutrition counseling at Urban Nutrition, LLC and understand that all information I provide is private, confidential, and protected by law a described in the Urban Nutrition, LLC Privacy Practices. When necessary to coordinate my nutrition and healthcare, and as described in the Urban Nutrition, LLC Privacy Practices, my protected health information may be obtained from and/or provided to my:

Insurance Company: _____

Primary Care Doctor: _____

Address: _____

Phone: _____ **Fax:** _____

Other Doctor: _____ **Specialty:** _____

Address: _____

Phone: _____ **Fax:** _____

Psychologist or Counselor: _____

Address: _____

Phone: _____ **Fax:** _____

Urban Nutrition, LLC is herby released from legal responsibility or liability for the release of information authorized herein. I understand that I have the right to revoke this authorization in writing at any time by sending notification to Urban Nutrition, LLC at the following address:

P.O. Box 1064
Colleyville, TX 76034

I understand that I have the right to (1) inspect or obtain a copy of the protected health information to be provided as permitted under federal and state law, and (2) refuse to sign this authorization. My signature indicates my understanding and acceptance of the above policies.

_____ _____

SIGNATURE OF PATIENT/GUARDIAN **DATE**

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