PRIMARY INSURANCE COVERAGE:

NAME OF PRIMARY INSURANCE COMPANY: _____

STREET ADDRESS _____

CITY:_____ STATE: _____ ZIP:_____

SUBSCRIBER #: _____INSURANCE GROUP # _____

CUSTOMER SERVICE NUMBER: _____

POLICY HOLDER'S NAME: _____

BIRTHDATE OF POLICY HOLDER: _____/_____/_____

SS# OF POLICY HOLDER _____/_____/_____

PATIENT RELATIONSHIP TO INSURED: { } SELF { } SPOUSE { } DEPENDANT

EMPLOYER OF POLICY HOLDER: _____

RESPONSIBILITY FOR PAYMENT

I understand and acknowledge the following terms and conditions for collection and payment of services provided:

I agree to complete necessary paperwork and provide a copy of my insurance card if from a participating insurance plan.

I agree to notify the office at least 24 buisness hours before a scheduled appointment if I cannot keep the appointment if possible. (emergencies excluded) A $25 cancellation fee will be assessed for missed appointments without notification, at the discretion of the office.

For Aetna, Anthem, Medical Mutual, and UnitedHealthCare:
I authorize Nutrition Advantage, llc to bill my health insurance plan for direct payment.

I agree to pay all co-payments and deductibles required by my plan.

I agree to pay for services rendered that are not covered by my plan.

For All Other Health Insurance Plans:
I agree to pay for services at the time they are delivered.

Signature of Client or Parent/Guardian _____
Date _____