Nutrition Advantage

Name: _____ Date: _____

DEMOGRAPHIC INFORMATION

TODAY'S DATE: _____

NAME LAST: _____ FIRST: _____ MI: _____

TITLE: ___MR ___MRS ___MISS ___DR ____OTHER GENER: ___M ___F

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER _____

ADDRESS Street/Apt: _____ City: _____ State _____ Zip: _____

PHONE Home: _____ Work: _____ EMAIL: _____

WHERE DO YOU PREFER WE LEAVE A MESSAGE? Home _____ Work _____

MARITAL STATUS: Single: _____ Married: _____ Divorced: _____ Seperated: _____ Widowed: _____

EDUCATION:(Highest grade completed or degree obtained)_____

SPECIAL CERTIFICATION _____

EMPLOYMENT STATUS: Full-Time:_____ Part-Time:_____ Retired:_____Unemployed:_____Disabled: _____

CURRENT EMPLOYER: _____ OCCUPATION: _____

CURRENT SCHOOL: _____ YEAR:_____ COURSE OF STUDY _____

IF PATIENT IS A DEPENDENT:
Residential Parent Name: _____

Non-Residential Parent Name: _____ Phone # _____

Address: _____

Email: _____

PERSON TO CONTACT IN EMERGENCY:
Name: _____

Home Phone: _____ Work Phone: _____

Address: _____

PRIMARY INSURANCE COVERAGE

Name of Primary Insurance Coverage:

_____

Street Address: _____

City: _____ State: _____ Zip: _____

Subscriber # _____ Insurance Group # _____

Customer Service Number: _____

Policy Holders Name: _____

Birthdate of Policy Holder: _____/_____/_____

Social Security Number of Policy Holder _____/_____/_____

Patient Relationship to Insured: _____ Self _____ Spouse _____ Dependent

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 to provide a copy of my insurance card if from a participating insurance plan.

I agree to notify the office at least 24 business hours before a scheduled appointment if i can not keep the appointment. (Emergencies Excluded) A $50 cancellation fee will be assessed for missed appointments without notification, at the discretion of the office.

FOR AETNA, ANTHEM, MEDICAL MUTUAL, & UNITED HEALTHCARE:
I authorize Nutrition Advantage, LLC to bill my health insurance plan for direct payment.

I agree to pay all copayments co-insurance amounts and deductibles required by my plan.

I agree to pay for services rendered that are not covered by my plan, including but not limited to all Anthem MediBlue Plans. Please verify with your health plan to determine coverage beforehand.

FOR ALL OTHER HEALTH INSURANCE PLANS:
I agree to pay for services at the time they are delivered.

Signature of Client/Parent Guardian: _____ Date: _____