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 pay all co-pays, co-insurance and deductibles required by my insurance plan. I also agree to pay any nutrition services that are not covered by my insurance, including but not limited to Anthem MediBlue plans. I understand that Medicare plans will likely not cover nutrition services.

I agree to notify the office at least 48 business hours before a scheduled appointment if I cannot 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 and deductibles required by my plan.

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

I agree to pay at the time of service if I have a **MEDICARE Plan**, or provide a credit card to have on file.
We will file your claim, and if denied, we will charge your card for the visit. Initial Here acknowledging and agreeing to this policy _____ Date _____

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

Signature of Client/Parent Guardian: _____ Date: _____

Credit Card Permissions

We will ask for your credit card information at your initial visit.
By signing below, you give Nutrition Advantage, LLC permission to keep your credit card on file and charge that credit card ONLY for the following:

1. AFTER we hear back from your insurance, we will charge your card for any co-pays, deductibles, co-insurance payments, or if your insurance denies the nutrition office visit.
2. If you are not using insurance, and are a self-pay client.

Receipts will be sent via email, or printed upon your request.

Signature of Client/Parent Guardian: _____ Date: _____