

PACIFIC NUTRITION & WELLNESS

NAME: _____ Referral Source _____
Social Security Number: _____ Birthdate: _____ Age: _____ Sex: _____
Mailing Address: _____ City, State, Zip: _____
Home Phone: _____ Day Phone: _____ Cell Phone: _____
E-mail: _____ Mention of email confirmations and newsletter Yes No
Primary Care Physician: _____ Phone: _____ Fax: _____
Address: _____
EMERGENCY CONTACT: _____ PHONE: _____

Intake Notes: known diagnosis and major concerns: Applicable diagnosis codes/meds: _____

Diagnosis or reason for visit: _____
Referring Provider: _____ **Phone:** _____
Are there any labs or records we should obtain? No Yes **Date requested:** _____

PRIMARY INSURANCE: _____ Name of Insured: _____
Relationship to Patient: _____ Insured's SSN: _____ Insured's Date of Birth: _____
Subscriber ID#: _____ Group #: _____ Copay Amt \$ _____
Insurance Company Address: _____
City, State, Zip: _____ Insurance Phone: _____ Effective Date: _____
Nutrition Benefits: Yes / No % _____ For Dx. Codes: _____, _____, _____ # of visits _____ Policy renewal date: _____
LOMN needed: Yes / No Chart notes need to be sent with claim: Yes / No Other _____
ARNP Benefits: Yes / No % _____ For Dx. Codes _____, _____, _____ # of visits _____ LOMN needed: Yes / No
Chart notes need to be sent with claim: Yes / No Other: _____
Name of Agent _____ **Date of Verification:** _____

Patient Notified of Benefits and Financial Responsibility Yes No

I hereby authorize my insurance benefits be paid directly to the provider. I am financially responsible for any balance due. I also authorize the Provider or Insurance Company to release information required for my claims. I consent to the release of medical information from or to other providers and healthcare institutions as is necessary to my care and treatment. I understand that this is a quote of benefits and not a guarantee of payment from my insurance company and that I am ultimately responsible for all balances due on account.

Patient Signature

Date

HIPAA NOTICE OF PRIVACY PRACTICES

Effective date: April 14, 2003

We understand that information about you and your health is personal. We are committed to protecting health information about you. We create a record of the care and services you receive from us. We need this record to provide you with quality care and to comply with certain legal requirements. This Notice applies to all of the records of your care generated by this office, whether made by your personal doctor or others working in this office. This Notice will tell you about the ways in which we may use and disclose health information about you. We also describe your rights to the health information we keep about you, and describe certain obligations we have regarding the use and disclosure of your health information.

We are required by law to:

- Make sure that health information that identifies you is kept private.
- Give you this Notice of our legal duties and privacy practices with respect to health information about you.
- Follow the terms of the Notice that is currently in effect.

How we may use and disclose health information about you:

- For treatment.
- For payment.
- For health care operations.
- For appointment reminders.
- As required by law.
- To avert a serious threat to health and safety.
- As required by the Military of Veterans and Worker Compensation.
- Public health risks.
- Health oversight activities.
- Lawsuits and disputes.
- Law enforcement.
- Coroners, health examiners and funeral directors.
- National Security and Intelligence activities.
- Protective Services for the President and others.
- Security Official for Inmates.

Your rights regarding Health Information about you:

- Right to Inspect and Copy.
- Right to Amend.
- Right to an Accounting of Disclosures.
- Right to Request Restriction.
- Right to Request Confidential Communications.
- Right to a paper copy of this Notice (full notice is available upon request).

Changes to this Notice:

We reserve the right to change this Notice. We will post a copy of this current notice in our facility with the current effective date on this first page.

Complaints:

If you believe that your privacy rights have been violated, you may file a complaint with us. All complaints must be in writing. Please contact the administrator at the location where you were treated to file a complaint.

Acknowledgement of receipt of this Notice:

We will request that you sign a separate form acknowledging you have received a copy of this notice. This acknowledgement will become part of your records.

PACIFIC | NUTRITION & WELLNESS

NOTICE OF PRIVACY PRACTICE- ACKNOWLEDGEMENT

We keep a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your records to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting the administrator of the location at which you have been treated. Please call the main office phone number and ask for the administrator.

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

By my signature below I acknowledge receipt of the Notice of Privacy Practice.

Patient or legal authorized individual signature

Date

Time

Printed name if signed on behalf of the patient

Relationship (parent, legal guardian, personal representative)

This area for staff notes (if any):

Financial Policy

Welcome to our practice, please review and sign our financial policy.

Referrals: If your insurance requires a referral please bring that with you on your first visit.

Initial

Insurance Plans: As a courtesy to our patients, we will file your claims for you to your insurance company, if we are contracted. If for some reason your insurance company declines to pay for the services rendered, or states prior to your appointment that this is a non-covered service, then you, the patient, are responsible for the entire bill. Any co-pays, co-insurance and deductibles will be collected at the time of service. We do not bill insurances we are not contracted with, nor do we bill secondary insurances. A receipt with all the necessary codes will be provided so that you can submit to your insurance for reimbursement.

Initial

Self-Pay Patients: Payments are due at the time services are rendered. We will notify you prior to your appointment what the charges will be. A receipt with all necessary codes will be available for you, the patient, to submit to your insurance for reimbursement.

Initial

Delinquent Accounts: Any accounts 90 days or older will be forwarded to our collection agency. The patient will be responsible for any fees incurred by Pacific Nutrition & Wellness to collect this debt. Fees included, but not limited to, are collection fees, attorney's charges and or court fees incurred by Pacific Nutrition & Wellness.

Initial

Return Check Policy: There is a \$15.00 service fee on each returned check. A NSF check must be redeemed with cash within 5 business days of bank notification.

Initial

Minor Patients: An adult or legal guardian must accompany all minors to each office visit. The adult or legal guardian accompanying the minor assumes all financial responsibility for the cost of the minor's visit.

Initial

Cancellation Policy: If you cannot make your scheduled appointment time, please contact our office 24-hours prior to your appointment. ***We will charge for any appointment missed or cancelled with less than 24 hours notice.***

Initial

For your convenience Pacific Nutrition & Wellness accepts the following forms of payment; Cash, Check, Money Order, Cashier Check, Visa, MasterCard, Discover, and American Express (a 2% fee will be added to all debit/credit card charges over \$500.00).

Initial

I have read and understand the above financial policy and agree to abide by the terms of this policy.

Patient Signature

PACIFIC | NUTRITION & WELLNESS

Welcome to Pacific Nutrition and Wellness. It is our goal to provide you with the best possible nutrition and fitness therapy for your individual needs. While nutrition and fitness therapy can help prevent chronic illnesses and alleviate certain problems it does not replace the need for medical care or medicine that your doctor has prescribed. It is important to contact your primary care physician with any medical concerns. All diets and recommendations are in compliance with the guidelines set by the American Dietetic Association. Your medical information is kept private however reports will be sent to your primary care physician unless you have requested in writing for them to not be sent.

I, _____, hereby agree to the following:

I understand that nutrition therapy is not a replacement for medical care. I do not hold Pacific Nutrition and Wellness liable for any medical problems that I have or am experiencing due to my dietary changes.

That I am participating in the Nutrition & Fitness Training Classes, Programs or Workshops offered by Pacific Nutrition and Wellness during which I will receive information and instruction about nutrition and fitness. I recognize that fitness programs require physical exertion that may be strenuous and may cause physical injury, and I am fully aware of the risks and hazards involved.

I understand that it is my responsibility to consult with a physician prior to and regarding my participation in Nutrition & Fitness Training, Classes, Programs or Workshops. I represent and warrant that I am healthy enough and have no medical condition that would prevent my full participation in the Exercise Training, Classes, Programs, or Workshops.

In consideration of being permitted to participate in Nutrition & Fitness Training Classes, Programs or Workshops, I agree to assume full responsibility for any risk, injuries or damages, know or unknown, which I might incur as result of participating in the program.

In consideration of being permitted to participate in Nutrition & Fitness Training Classes, Programs or Workshops, I knowingly, voluntarily and expressly waive my claim I may have against Pacific Nutrition and Wellness for injury or damages that I may sustain as a result of participating in the program.

I, my heirs, or legal representative forever release waive, discharge and covenant not to sue Pacific Nutrition and Wellness for any injury or death caused by their negligence or other acts.

I have read the above release and waiver of liability and fully understand its contents. I voluntarily agree to the terms and condition stated above.

Date

Signature of Participate

If participant is under 18:

AS LEGAL GUARDIAN OF _____, I CONSENT TO THE ABOVE TERMS AND CONDITIONS.

Date

Signature of parents/Guardian of Participant

Witnessed By: _____