

Family Nutrition Center of South Florida

Patient Information

Patient Name: _____ DOB: _____ Age: _____ Male: _____ Female: _____

Address: _____ City: _____ State: _____ Zip code: _____

Phone #: _____ Cell Phone: _____ SS# _____

Employment Information

Patient's employer: _____ Spouse's employer: _____

Address: _____ Address: _____

City: _____ State: _____ Zip code: _____ City: _____ State: _____ Zip code: _____

Phone: _____

Phone: _____

Payment Information:

All co-payments must be paid in cash. The office does not accept checks. Credit card/debit cards will be accepted for services exceeding \$50.00.

Private Pay: _____

Insurance Information (HMO's are accepted as form of payment if prior authorization/referral provided):
(PPO's are not accepted for payment -payment required at time of visit)

Insurance Company: _____

Health Information:

Reason for visit: _____ Medications: _____

Referring Health Care
Provider: _____

Address: _____

Please fill out the back of the form/attach insurance card, referral, and drivers license Thank you
Revised 5/04-#2

Financial Policy

The undersigned agrees, whether he or she signs as a guardian or as a patient, that in consideration of the services to be rendered to the patient, he or she hereby individually obligates him/herself to promptly pay the account of Lucille Beseler MS, RD, LD, PA. DBA Family Nutrition Center of South Florida. Provisional credit may be allowed for confirmed insurance benefits assigned to Lucille Beseler. All such provisional credits are subject to collections.

The office will file your insurance only if L. Beseler is a provider under your insurance plan, HMO, PPO. It is your responsibility to provide the necessary insurance information to do so, including authorizations. If this information is not provided at time of visit you will be required to make payment. If L. Beseler is not a provider under your insurance plan the office will not file your insurance. Your insurance is a contract between you and your insurance carrier and does not guarantee payment for nutrition services and/or payment to L. Beseler. This office can not become involved in disputes regarding claims, deductibles, co- payments, non-covered charges, or other denials of payment. The office is required to collect any patient responsibility, as this is part of our HMO/PPO contract.

If you have any questions regarding your insurance coverage please direct them to your insurance representative.

PLEASE BE ADVISED THAT THERE WILL BE A \$35.00 SERVICE CHARGE FOR ALL RETURNED CHECKS FROM THE BANK FOR ANY REASON. If you fail to pay your account, you will be responsible for any collection fees incurred. This includes a 33.3% processing fee if your account has to be placed with a third party for collection.

I have read this financial policy and understand my financial obligation:

Patient/ Parent/Guardian

Date

Appointments - Schedule

Your appointment consists of an individual counseling session. In order to continue to offer the ultimate in patient care we need your commitment. We request 48 hours notice from our patients when canceling or rescheduling an appointment. If you fail to provide us with advance notice of a cancellation, our staff is unproductive during that reserved time slot. This will ultimately effect the kind and cost of the service we provide.

In order to contain cost if anyone fails to notify us with less than 48 hours in advance of their scheduled appointment, a rescheduling fee of \$15.00 will be charged to their account (not your insurance company). This policy applies to all clients regardless of insurance coverage and is approved by all HMO's.

Please note lack of insurance referrals will not be considered a valid excuse as sufficient reminders are given for follow-up referrals. Ultimately, it is the patient's responsibility to be aware of their insurance and referral coverage. Please remember we make every effort to remind you of your appointment with written information mailed to your home and phone reminders. **The mission of the Family Nutrition Center is to improve the nutritional health of our clients not collecting rescheduling fees. Please assist us in maintaining good service.**

I understand the above policy: _____
Signature of patient or guardian of patient

I HAVE RECEIVED A COPY OF THE PRIVACY ACT FROM THE FAMILY NUTRITION CENTER:

SIGNATURE

DATE

revised 5/04 - #3