HBC
NUTRITION

DATE _____ **REFERRING PHYSICIAN** _____

PATIENT _____ _____
Last Name **First Name** **Middle Initial**

PHONE NUMBERS _____
Home **Work** **Mobile**

STREET ADDRESS _____

CITY _____ **STATE** _____ **ZIP** _____

E-MAIL _____

SEX _____ **M** _____ **F** **AGE** _____ **BIRTHDATE** _____

SOCIAL SECURITY NUMBER _____

PLACE OF EMPLOYMENT _____

PREFERRED METHOD OF CONTACT: **E-MAIL** ☐ **PHONE** ☐ _____

EMERGENCY CONTACT_____

NAME OF INSURANCE COMPANY _____

POLICY NUMBER _____ **CO-PAYMENT (SPECIALIST) $** _____

(CO-PAYMENT IS DUE ON DATE OF SERVICE)

SUBSCRIBER NAME _____
Last **First** **Middle**

DATE OF BIRTH _____ **SOCIAL SECURITY NUMBER** _____

RELATIONSHIP TO PATIENT _____

SECONDARY INSURANCE COMPANY _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with _____ (Insurance Company Name) and assign directly to HBC Nutrition, LLC all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions whether manual or electronic.

The undersigned understands and agrees that the account balance is due, in full, upon receipt of the statement. If the account is not paid in full within 60 days from the date the statement is received, the undersigned agrees to be liable for all costs of collections, including attorney's fees and court costs.

You agree, in order for us to service our account or to collect any amount you may owe, we may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or e-mails, using any e-mail address you provide to us. Methods of contact may include using pre-recorded/artificial voice messages and/or use of any automatic dialing devise, as applicable. In the event your account is place for outside collections, you agree this authorization remains valid.

Please provide your current insurance card or information at each visit.

Collection of Co-Payments and Payments to your bill: Payments of all known deductibles, co-payments, coinsurance, outstanding balances and non-covered charges will be expected and collected at time of service.

For out-of-network patients: Payment in full is expected at visit.

Patients with High Deductible Insurance plans: When benefits have been verified and patient has not met their deductible, we will require that you make **a $100.00 payment** at time of service.

Payment options for Payments: We accept Cash, Check, Visa, MasterCard, American Express, Discover and Venmo. There is a **$30.00 return check fee** for all return checks.

Past Due Balances: We require that past due balances be paid for in full prior to subsequent office visits. Outstanding balances may result in dismissal from our practice. If you are unable to make a payment please contact our office at 615-925-3894 to set up payment arrangements.

Late and Missed Appointments Policy: If you need to reschedule or cancel your appointment, we require a **minimum** 24 hours advance notice. Failure to notify the office or leave a message on the voicemail (voicemail is checked several times daily) will result in a **$75.00 Missed appointment charge**. This charge will be billed directly to you and you will be held responsible. A total of **3 no shows or missed appointments will result in a dismissal from our practice**. If you are more than 15 minutes late, we will need to schedule you another appointment and your account will be charged as a missed appointment.

Filing of Your Insurance: I hereby give my permission to file my insurance and my insurance benefits to be paid directly to HBC Nutrition. I agree to pay any non-covered services, deductible and copayments. I hereby authorize the release of pertinent medical information to insurance carriers.

I HAVE READ, UNDERSTAND AND AGREE TO THIS FINANCIAL POLICY

Patient Signature_____ Date _____

Patient Name (Print)_____

Patient/Representative Signature_____ Date _____

Patient/Representative Name (Print)_____

Relationship_____