Patient Name: ____

Date of Birth: ____

We want to make sure you are aware of what to expect from our practice. The following is a list of our Patient Policies that address consent for Medical Nutrition Therapy, Financial Responsibility, appointment cancellation, and an acknowledgement of receipt of the HIPAA Privacy Notice and clinical policies for the office of Goodness Nutrition Center,LLC. We ask that you read the policies and sign below.

CONSENT FOR MEDICAL NUTRITION THERAPY

Medical Nutrition Therapy includes nutrition assessment, diagnosis, interventions and monitoring considered necessary or advisable in the judgment of the Registered, Licensed Dietitian and/or the Physician. I am aware that nutrition is not an exact science, and I acknowledge that no guarantees have been made to me as to the result of interventions.

PATIENT FINANCIAL RESPONSIBILITY

This is a statement of our financial policy. You understand that you are obligated to pay our fees in full at the time of service unless a prior agreement has been made with our billing department.

FORMS OF PAYMENT ACCEPTED: check, cash, credit card, PayPal

At this time, Goodness Nutrition Center LLC accepts several insurance and Medicare. It is your responsibility to provide the correct information and referral when applicable. Furthermore, we will provide you with a detailed paid receipt as needed for submission to your medical insurance for reimbursement. Receipts for our services can also be applied toward a Flex Spending account.
Should your insurance company deny coverage, you are financially responsible for the payment.
I have read the financial policy and understand my financial obligation.

Patient ____________________________Parent/Guardian ________________Date _______

Credit Card Holder Authorization

I, the previously authorized credit card user, give Goodness Nutrition Center, LLC express authorization to charge my credit card for the purpose of 1) Payments for services rendered by the practitioner at Goodness Nutrition Center; 2) Payments for any outstanding balance incurred. I understand this form constitutes a legally binding contract and by affixing my signature to this form, I am responsible for the agreed-upon (outlined above) charges as well as any and all collection and legal fees. This credit card applies exclusively for charges noted above.

I have read the financial policy and understand my financial obligations.

Patient ____________________________Parent/Guardian ________________Date _______

<u>Cancellation Policy</u>: We reserve your appointment time specifically to work with you. When cancellation is a must, a minimum of **24 hours' notice is required**. Failure to cancel 24 hours in advance will result in a **$ 30 fee.**

I have read and understand the cancellation policy.

Patient ____________________________Parent/Guardian ________________Date _______

PATIENT CONFIRMATION OF RECEIPT OF PRIVACY NOTICE

I have received the HIPAA Privacy Notice for the office of Goodness Nutrition Center, LLC **available in the reception area of the office.**

Patient ____________________________Parent/Guardian ________________Date _______