

 **Patient Acknowledgment Form**

**Patient Information:**

* **Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**
* **Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Welcome to **Goodness Nutrition Center, LLC**. To ensure transparency and facilitate a smooth experience at our practice, we kindly request your acknowledgment of the following patient policies. Please carefully read and sign below to confirm your understanding and agreement.

**1. Consent for Medical Nutrition Therapy:** I acknowledge that Medical Nutrition Therapy involves nutrition assessment, diagnosis, interventions, and monitoring as deemed necessary by the Registered, Licensed Dietitian and the Physician. Understanding that nutrition is not an exact science, I acknowledge that no guarantees have been made regarding the results of interventions.

**Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_**

**2. Payment Methods:** Accepted forms of payment include check, cash, credit card, and PayPal.

**Insurance Coverage:** We currently accept Aetna, Ambetter, Cigna, Humana, United Health Care Medicare Insurance, and Medicare. Please provide accurate information and necessary referrals. Receipts can be provided for insurance reimbursement or Flex Spending accounts.

**Patient Financial Responsibility**: I have read and understand the financial policy. I agree to pay all fees in full at the time of service unless a prior agreement has been made with the billing department. I know the accepted forms of payment and insurance coverage, and I understand that I am responsible for providing accurate information and referrals. In the event of insurance denial, I accept financial responsibility for the payment.

**Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_**

**3. Credit Card Holder Authorization:** I authorize Goodness Nutrition Center, LLC, to charge my credit card for services rendered and outstanding balances. I understand this authorization is a legally binding contract, and I am responsible for the agreed-upon charges, including any associated collection and legal fees.

**Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_**

**4. Cancellation Policy:** I acknowledge the $50 fee for cancellations made within 48 hours of the scheduled appointment. I understand the importance of providing at least 48 hours' notice to avoid the fee.

**Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_**

**5. Patient Confirmation of Receipt of Privacy Notice:** I confirm that I have received the HIPAA Privacy Notice for Goodness Nutrition Center, LLC, available at the office.

**Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_**

**We appreciate your cooperation in acknowledging these policies. If you have any questions or concerns, please do not hesitate to contact our office.**