

Patient Information

Please attach a copy of your driver's license or photo ID and insurance card

Patient Name: _____ Date of Birth: _____ Age: _____

Patient Home Address: _____ Apt. _____

City: _____ State: _____ Zip code: _____

Patient Home Phone #: _____ Cell Phone #: _____ Work# _____

Adults only: Include Email to Authorization correspondence this way: _____

Guarantor for Payments Name if different: _____

Mailing Address if different than above: _____:

Home Phone #:() _____ Cell Phone #:() _____

If Child, list legal guardian or parent name/s:

(Parents address ONLY if different from child):

Mother's Name: _____ Father's Name: _____

Mothers Address: _____ Father's Address: _____

Telephone's #

Mother _____ Father _____

Parents are: Living Together Separated Divorced If Divorced, who is the Custodial Parent _____

Names of individuals, and relationship, (other than parent who are older than age 17) of persons whom I give permission to bring in my child and be responsible for carrying out the directives given to them by Linda Arpino & Associates, Inc. Please note that the person bringing in the child is responsible for payment.

Name _____ Relationship _____ Cell phone _____

ALL CHILDREN UNDER AGE 18 MUST BE ACCOMPANIED BY A PARENT OR LEGAL GUARDIAN

Employment Information

Name of Employer: _____

If Minor, Parents Employer. Work Telephone #() _____

Address: _____

City: _____ State: _____ Zip code: _____

Payment Information:

All payments are required at the time of the visit unless the below insurance coverage has been verified and our office is a provider for your plan. All co-payments must be paid at the time of the visit and in cash if under \$50. The office does not accept payments with credit cards or checks under \$50, payment. For FEES exceeding \$50.00 we accept Cash, Check or Credit Card (VISA, MASTER CARD ONLY)/debit cards. Private Payers: This visit will not be submitted for third party payment or insurance coverage, check here: _____ CONTINUE ON NEXT PAGE

Insurance Plan Nutrition Counseling Coverage Verification: It is your responsibility to check your health insurance policy before you come for your first visit even if you think there is **nutrition** coverage under your plan and we are a provider. In order to keep our cost to you down, we require you to check if you have nutrition counseling as an insurance benefit before we accept your plan, otherwise payment is required at the time of the visit. Please verify the following before your consult: Do you have a Deductible: _____ Amount currently satisfied _____ Co-insurance requirement _____ % Limit on Number of visits per year allowed _____ Does your plan coverage the DIAGNOSIS or preventative reason for this visit? Yes, it covers for (reason for your visit) _____ No my plan does not cover for _____ Have you verified that we are an accepted provider for your plan? _____ Is a physician referral required? _____ yes _____ no

Insurance Details

(PLEASE PROVIDE A COPY OF THE PATIENTS CARD AND PHOTO ID OF THE PRIMARY HOLDER, WE MUST HAVE A COPY OF YOUR MOST CURRENT INSURANCE CARD FOR OUR RECORDS and If required, INSURANCE REFERRAL FAXED TO OUR OFFICE (866)293-4500)

Name of PRIMARY HOLDER, if different than patient _____

DATE of BIRTH: _____ ADDRESS of Primary Holder, if different than patient.

Street _____

City _____ State _____ ZIP _____

Relation to Primary Holder circle one: self/ mother /father /spouse

Patient ID#: _____ Group #: _____

Authorization #(if applicable) _____ Referral# if applicable _____

Health Information:

Reason for visit _____

Who can we thank for referring you? _____ friend/family _____ Life Focus Nutrition Website
_____ MD _____ insurance network directory _____ other, _____

List All Current Medications: _____

Current Medical Conditions: _____

List all Herbal, Vitamin, Mineral or other Supplements here: _____

Authorization and Release to Communicate Medical/ Health Details and send reports to:

Name of Primary Physician: _____ Telephone #(_____) _____

Address: _____ Fax# _____

List other health care providers treating this patient

Name/s:

1) _____ 2) _____ 3) _____

Address/s:

Telephone #'s:

1) _____ 2) _____ 3) _____

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 Linda Arpino & Associates, Inc. (LAA) Provisional credit may be allowed for confirmed insurance benefits assigned to Linda Arpino. All such provisional credits are subject to collections.

Please note, it is the patient's responsibility to be aware of their insurance and referral coverage. The office will file your insurance only if Linda Arpino is a provider under your insurance plan and you have written confirmed nutritional counseling as a covered benefit

It is your responsibility to provide the necessary insurance information to do so, including authorizations before or at the time of your visit. If this information is not provided at time of visit you will be required to make payment. Commonly asked questions to third party payers are listed on our website lifefocusnutrition.com, click tab-office details. If Linda Arpino is not a provider under your insurance plan the office will not file your insurance and payment is required at the time of your appointment. Your insurance is a contract between you and your insurance carrier and does not guarantee payment for nutrition services and/or payment to LAA. This office cannot 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 provider HMO/PPO contracts.

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 35% processing fee if your account has to be placed with a third party for collection.

Your appointment consists of an individual counseling session. In order to continue to offer the ultimate in patient care we need your commitment. Help us run smoothly, we request 24 hours notice from our patients when canceling or rescheduling an appointment. **If anyone fails to notify us with less than 24 hours in advance of their scheduled appointment, we lose valuable time, a \$50.00 fee will be charged to your account (not your insurance company). This policy applies to all clients regardless of insurance coverage. The mission of Linda Arpino & Associates is to improve the nutritional health of our clients not fee collection so please assist us in maintaining good service.**

I have read the HIPPA Compliance form and fully understand the above disclosure and policies.

I HAVE RECEIVED A COPY OF THE HIPPA PRIVACY ACT FROM Linda Arpino's office or website and the LIFE FOCUS NUTRITION CENTER.

I HAVE READ AND UNDERSTAND MY FINANCIAL RESPONSIBILITY AND ATTEST TO ACCURATE INFORMATION FOR THE ABOVE PATIENT.

Patient Name: _____

Print Garrantor name here if different: _____

Signature Of Guarantor, if Minor Guardian/Custodial Parent Of Patient

Date