Monadnock
Nutrition Services

Personal Information

Name of Patient:		Date:
Home Address:		
City:	State:	Zip:
Date of Birth:	Marital Status:	Age:
Social Security #:	Email Address:	
Telephone: Home:	Work:	Cell:
Occupation:		
Employer:		
Referred by:		
Reason for Referral:		
Primary Care Physician (PCP):		
Telephone # of PCP:	Fax:	

Health Insurance Information

Health Insurance Company:	Provider Services Phone Number (located on back of insurance card):
Identification Number:	
Subscriber Name:	
Subscriber Date of Birth (DOB):	
Subscriber Employer:	
Relationship to Patient:	
Secondary Insurance Company:	

Policies Concerning Fees and Payment

Authorizations: I hereby direct my insurance carrier to make payments directly to the Provider for health insurance benefits otherwise payable to me, but not to exceed the Provider's regular charges of $250.00 for initial visit or $200.00 for follow up visit, with an additional $62.50 for each quarter-hour unit over 60 minutes for an initial visit, and $50.00 for each quarter hour over 50 minutes for a follow-up visit.

I understand that I am financially responsible for charges not covered by this authorization (including insurance co-payments, co-insurances and deductibles that are due at the time of service). This assignment of benefits shall be valid for the duration of my treatment.

I also hereby authorize the Provider and the office billing staff or agency to release to my insurance company any billing and medical information necessary to process claims for services rendered to me by the Provider. This authorization is limited to the release of only that information necessary to substantiate and process health insurance claims and excludes such confidential information, which by law may only be released by specific consent.

I also consent to treatment for nutritional counseling for myself or my dependent listed above.

Signature of Patient/Guardian:_____Date:_____

For Office Use Only:
Dx-1_____Dx-2_____Referral #:_____# of visits:_____