SHS Nutrition, LLC

Registration Form

Patient's Name:_____ Date:_____

Parent's Name: _____ (if under 18)

Mailing Address:_____

City:_____ State:_____ Zip Code:_____

Home Number:_____ Cell Number:_____

Email address:_____

Date of Birth:_____Age:_____

Occupation:_____Employer:_____

Primary Insurance
Company:_____

Insurance ID:_____

Primary Insured's Name:_____

Primary Insured's Date of Birth:_____ Relationship to Insured:_____

Insured's
Employer:_____

Secondary Insurance
Company:_____

Insurance ID:_____

Secondary Insured's Name:_____

Secondary Insured's Date of Birth:_____ Relationship to Insured:_____

Primary Physician's Name:_____ Physician's Phone:_____

Physician's
Address:_____

Referring Physician's Name:_____ Physician's Phone:_____

How did you hear about SHS Nutrition?

_____

SHS Nutrition, LLC

Insurance Payment and Release of Information Authorization

Name of Patient:

Health Insurance ID number:

Health Insurance Plan Name:

I, _____, authorize payment of medical benefits of SHS Nutrition, LLC for services furnished to me by them. I also authorize the release of any medical or other information necessary to process claims for medical benefits. I understand that regardless of my insurance coverage, I am responsible for payment of all fees for services rendered to me. If, for any reason, any fees are not paid by my insurance company, I understand that they must be paid by me. Additionally, where applicable, I will render co-payments, co-insurance payments, and deductibles at the time of service. Once service has been provided, there are no refunds or credits given.

I am absolutely responsible for paying SHS Nutrition all amounts my insurance company states are being applied to deductibles, copays, coinsurance, pre-existing conditions clauses, coordination of benefits, amounts in excess of benefit and lifetime maximums, and the like.

I am responsible for paying the full billed charge should I fail to obtain any referrals required by my insurance company or if my insurance changes or terminates and I fail to notify SHS Nutrition prior to services being rendered.

Failure to pay a bill sent to me within 30 days of the date on the invoice will result in a $20.00 late payment fee. Any payments made directly to me or my dependents owing to SHS Nutrition will be remitted immediately, payable to SHS Nutrition, LLC.

I understand that I will be responsible for the payment of any attorney fees, court costs, and collection costs that SHS Nutrition incurs to collect the amounts owed.

_____
Patient Signature

_____
Date

Patient Written Acknowledgment Confirming Receipt of Privacy Notice

I have received SHS Nutrition's HIPAA Privacy Notice.

_____(patient/client signature)

_____(date)

SHS Nutrition, LLC

Dear Patient,

In an effort to respect your time no appointments will be double booked. I would ask that you please respect our time as well as the time of other patients who may want that time slot. We try to make ourselves available through various forms of communication for your convenience. You can call, email, or text your cancellation to the contact information below.

Failure to cancel within 24 hours may result in a $60 no show fee. I appreciate your time and understanding.

Sincerely,

SHS Nutrition, LLC

appointments@shsnutrition.com

_____ Patient Signature

_____ Date