Patient Consent to Use and Disclose Health Information

It is our intent to protect your privacy and not disclose any of your client identifiable information to inappropriate sources. We use your information to communicate with your physician as well as to use the information to treat and file insurance and payment purposes. We ask for your consent to use and disclose information needed to provide medical nutrition therapy. Additional information may be found in our Health Insurance Portability and Accountability Act (HIPAA) brochure you receive at the time of your visit. Your signature will indicate you are giving us permission to use your information as indicated and also that you have received the HIPAA information.

Signature for consent: _____Date:_____

Witness: _____Date:_____

To further protect your personal information, please respond by checking one of the following:
A message _____**may** or _____**may not** be left on my home phone reminding me of my appointment.

Please share with us persons allowed to have access to your personal information.
Name: _____Relationship:_____Phone#_____

Name: _____Relationship:_____Phone#_____

If you **do not** wish for your information to be shared, please check _____do not share

FINANCIAL POLICY

Co-pays are required at the time services are rendered. Dietitian Associates, Inc. accepts cash, personal checks, VISA, MasterCard and Discover. There is a service charge of $40.00 for returned checks.

INSURANCE: We will gladly bill your insurance company as a courtesy to you; should your insurance not cover this service, you will be responsible for the full payment. Although we cannot guarantee insurance reimbursement, we will make every effort to help obtain coverage for our services. If you need assistance or have questions, please contact us between 8:00 a.m. and 5:00 p.m., Monday through Friday at (901) 759-9337.

REFUNDS: Overpayments will be refunded to the responsible party within 30 days. Oftentimes patients may receive their EOB a few days before DA receives theirs.

MISSED APPOINTMENTS/LATE CANCELLATIONS: Please remember that broken appointments represent a cost to us, to you and to the other patients who wish to make an appointment. Cancellation notice given less than 48 hours prior to appointment or skipped appointments may result in a $50 charge.

AUTHORIZATION: I have read and understand Dietitian Associates' Financial Policy. I authorize release of information to my insurance company for billing purposes. I further agree to assign insurance benefits to Dietitian Associates, Inc.

Signature of Insured or Authorized Representative:

_____ Date: _____