"Providing Tools and Enhancing Skills To Improve Your Nutritional Health"

Patient Intake Form

Welcome To AM Nutrition Services!

Please fill out all information, initial below and sign

Patient Name _____ DOB _____

Address _____City_____Zip_____

Cell # _____ *(we use text confirmation)* Email_____

Spouse/Caregiver _____ Permission to speak with this person?

If patient is a minor, parents' names _____

INSURANCE INFORMATION:

Primary Insurance: _____

Who is the Insured ? SELF or _____DOB _____

AM Nutrition Services Policies, please initial each and sign below:

_____I, the undersigned, certify that I or my dependent has **insurance coverage** with the above-mentioned carrier and assign directly to AM Nutrition Services all insurance benefits and reimbursements. If any fees are not covered by insurance, I understand that I am financially responsible for all charges (**copays, deductibles**). I authorize AM Nutrition Services to file claims on my behalf and to release all information necessary to secure payment. Please notify us prior to any appointments if you have a change in your insurance coverage.

_____**HIPAA NOTICE**: I understand my information may be released for treatment, payment, and operations issues. I understand that my dietitian may speak with other healthcare providers in order to coordinate my care. I have read and understand the AM Nutrition Services Notice of Privacy Practices. The entire HIPAA document is on display at the front desk for my review.

_____AM Nutrition Services policy requires a minimum of **48-hour notice** to cancel an appointment. If an accumulation of 3 cancellations without prior notice and/or no shows occurs, we reserve the right to discharge that patient from the practice. Please note the phone number of your office location for any reschedules.

_____ I acknowledge and understand that my healthcare provider participates in Contexture (Arizona HIE) and HealtHIE (Nevada HIE). I understand that my health information may be securely shared through the HIE, unless I complete and return an Opt Out Form to my healthcare provider.

_____I consent to receive text messages from AM Nutrition Services for appointment reminders, follow-up instructions and general health information. I may opt-out of receiving text messages at any time by notifying AM Nutrition Services in writing.

_____ **For Medicare patients only,** it is expected for Medicare to pay for Nutrition Services for ONLY patients with Kidney Disease and/ or Diabetes. If you are a Medicare patient and do not have either of these diagnoses, we will run your secondary insurance. If no secondary insurance is available, appointments will be out of pocket.

_____ **For Minor patients (ages 0- 14) only,** I consent that a parent, legal guardian, or an authorized proxy will be present at time of the nutrition appointment.

Signature _____ Date _____/_____/_____