7656 W. Sahara Ste 110, Las Vegas, Nevada 89117
Phone: (702) 525-1105 Fax: (702) 666-8555

Patient Registration Form

Patient Information

Last Name:______________________________________First Name:________________________ MI_______

Mailing Address:_________________________________City/State/Zip:______________________________

Physical Address:________________________________City/State/Zip:______________________________

Primary Phone:___________________________________ Type: Home/Cell/Work **Message ok?** Y or N_____

Alternate Phone:_________________________________ Type: Home/Cell/Work **Message ok?** Y or N_____

Email:____ Used for **Doctor Contact** Y or N **Newsletter** Y or N

Social Security Number:___________________________Date of Birth:________________________Male/Female

Marital Status: S M D W O ____________________________________

Employer:____Occupation:__________________________________

Referring Physician or Current Primary Physician:____

Responsible Party Information (Parent information if patient is a Minor)

Name:____

Address:______________________________City/State/Zip:____

Primary Phone:_________________________Alternate Phone:____

Insurance Information

*Primary Insurance Company Name:____

*Patients Relationship to Insurance Subscriber: Self/Spouse/Child/Other

*Name of Subscriber:____________________________________*Date of Birth:___________________________

*Social Security Number:_________________________________Male/Female

*Insurance ID#:________________________Group#:__________________________Effective Date:_________

*Secondary Insurance Company Name:____

*Patients Relationship to Insurance Subscriber: Self/Spouse/Child/Other

*Name of Insured:_____________________________*Date of Birth:____________________

*Social Security Number:_______________________________________Male/Female

*Insurance ID#:__________________Group#:___________________Effective Date:_______

Emergency Contact Information

Name:________________________Relationship:_________________________________

Primary Phone:___________________Alternate Phone:______________________________

I certify that the above is true and correct to the best of my knowledge. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all insurance submissions.

Patient/Responsible Party Signature: ____

Responsible Party's Relationship to Patient: ____

Today's Date: ______________________________

YOUR DIETITIAN FOR DIABETES & WEIGHT CONTROL, LLC
7656 W. Sahara Ste 110
Las Vegas, NV 89117

Dear Valued Patient,

As a Registered Dietitian & Certified Diabetes Educator, my services are personalized to your needs and comfort level. It is my goal to provide you with an understanding of your medical condition, such as diabetes, medications, and the effects of diet and exercise on disease management. At each visit, we will set a treatment plan with action items that will positively affect your health. ***At this time, I have contracted other Registered Dietitians to work within my business. Your dietitian provider has been chosen by your current medical condition, medications, referring physician and/or your laboratory results.***

I accept all insurances, however, at this time; I am not contracted with all insurance carriers.
When insurance companies process a claim for an out-of-network provider one of two things happen; 1) The insurance carrier will apply the entire charged amount to the patient's out-of-network deductible or 2) The insurance company will deny the claim in it's entirety making the subscriber financially responsible for the full billed amount. Understanding the financial burden this would create I have significantly reduced my fees to $90.00 an hour per 60 minute visit & $50.00 for a 30 minute visit for patients who have insurance which I am not yet contracted with.

It is your responsibility to pay any deductibles, co-pays or remaining balances to your account upon receipt of your statement. If your account has a balance after 6 months from the date of service, we will send your account to our collection agency, Plus Four Inc, to collect payment and additional interest and fees may apply.

Financial Policy

Private Insurance Authorization:

I understand that it is the policy of Your Dietitian for Diabetes & Weight Control to accept assignment of benefits with my insurance carrier. Angie Lopez, RDN, LD, CDE and other contracted Registered Dietitian (s) are or are not a contracted provider with my insurance carrier. Until said time that Angie Lopez, RD, CDE becomes contracted, I agree to be financially responsible for $90.00 per hour visit and $50.00 per 30 minute visit. I understand that I will be charged $25.00 (sat $50.00) for appointments cancelled with less than 24 hour notice, I will incur a $25.00 fee for any returned check(s), and that balances outstanding over 30 days are subject to 1.5% interest per month or 18% per annum.

I understand my signature requests payment be made to Your Dietitian for Diabetes & Weight Control and authorizes release of medical information necessary to pay the claim.

I have read, acknowledge, and agree to the above mentioned terms. This policy will remain in effect until Angie Lopez, RDN, LD, CDE and other contracted Dietitians become contracted providers with my insurance carrier or until I revoke it in writing.

____ ______________________

Patient and/or Responsible Party Signature Date Signed

YOUR DIETITIAN FOR DIABETES & WEIGHT CONTROL, LLC
7656 W. Sahara Ste 110
Las Vegas, Nevada 89117
(702) 525-1105

Financial Policy

Medicare:

I request that payment of authorized benefits be made to Your Dietitian for Diabetes & Weight Control for services rendered to me. I understand my signature requests payment to be made and authorize release of medical information necessary to pay the claim. If other insurance is indicated in box 9a of the CMS 1500 Form, or elsewhere on an electronically submitted claim, my signature authorizes releasing of the information to the insurer or agency shown. Your Dietitian for Diabetes & Weight Control agrees to accept the charge determination of my insurance carrier as the full charge and that I the patient am financially responsible for the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of my insurance carrier.
I understand that I will be charged $25.00 ($50.00 for Saturdays) for appointments cancelled with less than 24 hour notice, I will incur a $25.00 fee for any returned check(s), and that balances outstanding over 30 days are subject to 1.5% interest per month or 18% per annum.

I have read, acknowledge, and agree to that above stated terms. My authorization will remain in full effect until I revoke it in writing.

____ ____________________

Patient or Responsible Party Signature **Date Signed**

Patients Paying Privately (no insurance)

I understand it is the policy of Your Dietitian for Diabetes & Weight Control to require payment in full at the time of service. I understand that I will be charged $25.00 for appointments cancelled with less than 24 hour notice, I will incur a $25.00 fee for any returned check(s), and that balances outstanding over 30 days are subject to 1.5% interest per month or 18% per annum.

I have read, acknowledge, and agree to that above stated terms. My authorization will remain in full effect until I revoke it in writing.

____ ____________________

Patient or Responsible Party Signature **Date Signed**

YOUR DIETITIAN FOR DIABETES & WEIGHT CONTROL, LLC
7656 W. Sahara Ste 110
Las Vegas, Nevada 89117

Health Information Practices Notice

Law requires the privacy of your health information to be maintained as confidential and not shared with any outside parties. Your Dietitian for Diabetes & Weight Control will not disclose any of your health information to any outside organizations, with the exception and purpose of:

- Professional referral to another provider, hospital, or clinic for the diagnosis, assessment, or treatment.
- Collection of payment for services rendered (i.e. your insurance company)
- Office administration including phone calls. If you are not available to receive a call, a message will be left on your answering machine.

This is a summary of our disclosures practices. Full disclosure packet is available upon request at the front desk.

I understand that if I wish to place any restrictions on Your Dietitian for Diabetes & Weight Control, LLC Health Information Policy, I must make my request in writing. My request can be placed at any time. Your Dietitian for Diabetes & Weight Control will review my request and respond within 30 days. I will address concerns to;

Your Dietitian for Diabetes & Weight Control, LLC

Angie Lopez, RDN, LD, CDE

7656 W. Sahara Ste 110

Las Vegas, Nevada 89117

____ ____________________

Patient Date Signed

CANCELLATION & NO SHOW POLICY AGREEMENT

At Dietitian for Diabetes & Weight Control we give each patient our full attention for the highest level of care. **We do not double book appointments**, unlike your physician who may schedule several patients in the same time slot. If you do not attend your scheduled appointment, we are not reimbursed by your insurance provider and your dietetic provider is not being paid.

We understand that situations may arise in which you need to cancel or reschedule an appointment. Please notify us **at least 24 hours in advance** if you are unable to attend your appointment. This allows us to schedule other patients or let the dietetic provider adjust her personal schedule.

Any unconfirmed appointments, cancellations made in less than 24-hours, arrivals more than 20 minutes late or "no shows" will be charged a $25.00 fee. If you are scheduled on a Saturday the fee increases to $50.00.

If you acquire three fees in a 12-month period you will be dismissed from the practice and denied future appointments.

Appointments must be confirmed no later than 6 p.m. the night before your visit. Unconfirmed appointments will be cancelled and you will be charged a fee of $25.00.

Please speak to your dietitian if you have questions about the cancellation & no show policy. We believe in providing the best care to our patients and we look forward to helping you reach your goals!

______________________________ Patient Name (PRINT)

Date ______________________

______________________________ Signature

Appointment Reminder

Please provide the **best contact** telephone number for appointment reminders or email. Once you receive a text or voice reminder we ask that you confirm your appointment as soon as possible. We are using an **automated confirmation** system so please **READ** and reply as stated in the reminder (it is usually a number). You can leave a voicemail or text our office 24-hours a day at 702.525.1105.

Telephone ______________________________

Email: ______________________________

Do you prefer text or voice confirmation? ☐ TEXT ☐ VOICE ☐ EMAIL