

Amy C. Bluntzer, RD, LD
Nutrition Therapy
(512) 689-9535

CLIENT INFORMATION

Name: _____ Parents' Names: _____
Address: _____ City: _____ Zip: _____
Preferred Phone: _____ (Is this: home /work /cell?)
Email: _____ Child's Date of Birth: _____
Referring Physician: _____
Primary Insurance Company: _____ Type of Plan: HMO PPO POS
Primary Card Holder's Name: _____ His/Her Date of Birth: _____
Card Holder's Employer: _____ Insurance ID#: _____

OFFICE POLICIES

It is customary to pay for professional services when rendered unless prior arrangements have been made. The client is fully responsible for all fees, regardless of insurance coverage. I accept cash and checks. I will work with you to develop a payment plan if necessary. Package rates are available and are good for six months from date of purchase.

If your insurance is a HMO for which I am a provider:
I require a copy of your insurance card, your co-payment, and authorization number.

If your insurance is a PPO or POS for which I am a provider:
I will require a copy of your insurance card and specialist co-pay. Please check with your insurance company to make sure your diagnosis is covered prior to your appointment. If your insurance declines coverage, you will be responsible for paying for services at the billed rate.

If you are private pay:
I require payment in full at the time of the appointment, by cash or check. If you are hoping to get reimbursement from your insurance company for out of network services, I will provide you with a receipt of full payment that you can submit to your insurance company.

I authorize release of any medical or other information necessary to process my claims. I request that payment be made to Amy Bluntzer, RD, LD for these services. I understand that my insurance carrier may not cover payment for this service and therefore I will be responsible for payment.

Parent's signature: _____ Date: _____

Patient Written Acknowledgment Confirming Receipt of Privacy Notice

I have received Amy C. Bluntzer, RD, LD HIPAA Privacy Notice.

Parent's signature: _____ Date: _____