



Laura Mangum, RD, LD Consulting Dietitian
(512) 731.8679

CLIENT INFORMATION

Name: _____ Social Security #: _____ - _____ - _____ Date: _____
Address: _____ City: _____ Zip: _____
Phone:(hm) _____ (wk) _____ (cell) _____ Email: _____
Ethnic Group: (circle) African-American Asian Caucasian Hispanic Other: _____
Sex of patient & subscriber (circle one): Male Female
Date of Birth: _____ Referring Physician: _____ Primary Physician: _____
Primary Insurance carrier: _____ Type of Plan: HMO PPO POS
Primary Card Holder Name: _____ Please select: His/Her Date of Birth: _____
Primary Card Holder's Employer Name: _____
Reason for Appointment: _____

OFFICE POLICIES

In order to effectively manage this small business and secure payment for our services, we have established the following policies: By initialing below, I understand that I have read and agree to written policies.

_____ We require **24-hour** notice for canceling or rescheduling appointments. If we do not receive this advance notice, you will be charged a \$60 missed appointment fee. This policy has been implemented in consideration for those clients who may be waiting for services.

_____ It is customary to pay for professional services at the time of the appointment. As a courtesy, our office will file the claim with your insurance company, if you have nutrition coverage. However, the patient or responsible party will be responsible for any outstanding balances on the account. **After 45 days, an outstanding balance will be charged to the credit card on file. If the account becomes delinquent, it will be turned over to a collection agency with an additional processing fee added.**

_____ I hereby authorize Laura Mangum RD, LD to file claims with my insurance company and to receive payment for professional services. **I also understand that I am financially responsible for all charges not covered by my insurance.** I further authorize payment directly to Laura Mangum of all insurance benefits related to my care. **I understand that I am responsible for any co-payments, deductibles, or co-insurance due at the time of any and all office visits.**

_____ **I authorize Laura Mangum's office to charge my card on file for all outstanding balances.**

If a referral is required: (HMO and HealthSelect plans)

We will require a copy of your insurance card; your co-payment, authorization number and the correct name of the insurance company or health plan to be billed. If this information has not been obtained we will expect full payment for the services or we will need to reschedule the appointment.

A copy of the official referral (obtained from insurance company) is required for HMO and HealthSelect plans, and must be obtained prior to the appointment or referral must accompany patient at scheduled office visit. If a referral is not on file at the time of the scheduled appointment, patient will be expected to private pay or reschedule.



If your insurance is PPO or POS:

— We 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 company declines coverage, you will be responsible for paying for services at the billed rate.

If you are private pay:

— We require payment in full at the time of the appointment, by cash, check or credit card.

— I authorize the release of any medical or other information necessary to process my claims. I request that payment be made to Laura Mangum 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.

— I authorize Laura Mangum RD, LD to release medical information to the following providers:

- 1.) _____
- 2.) _____
- 3.) _____

— I authorize Laura Mangum RD, LD to release medical information to the following family members/friends:

- 1.) _____
- 2.) _____
- 3.) _____

Signature: _____

