integrated
nutrition therapy

Thank you for contacting our practice and scheduling an appointment. Your initial visit may last approximately 60-90 minutes.

Our website, ***Integratednutritiontherapy.com,*** has important information about the practice including profiles of our clinicians. This paperwork can also be found on the website if needed.

For your convenience, I have attached the new patient forms (4 forms) for you to print or electronically fill out. Please complete these forms and **return them within the next 2 business days along with your insurance ID card-both sides & driver license (photo ID).**

Patrice@integratednutritiontherapy.com or Fax: 609-642-1438

If your appointment is with Leah Frazee and in person, you can bring this paperwork to the appointment.

For an IN PERSON appointment: The address is **17 Barclay St., Ste B-3, Newtown, PA 18940**

We are located 1 block off of S. State Street. Our building is called **Barclay Commons**. It is brick and shingle with glass doors on the front. Please walk along the upper concrete ramp to the B side, outside building will say B and Bucks Support Services. Proceed up the stairs through the door that says B3. There is no receptionist, so kindly have a seat in the waiting room and Leah or Loni will be out to get you.

For your copay or other out of pocket costs, we accept cash, personal check, Visa, MasterCard, American Express or Discover for payment of our services. ***We also require credit card authorization as a commitment to our cancellation policy.***

We recommend that you send the following as well:

- A list of your current medication(s) and dosage including OTC, Vitamins & Supplements
- Your most recent blood work results (if applicable)
- Results of any other tests (if applicable)
- For Age 3 yrs. to 17 yrs.—Growth Chart (contact your pediatrician for this chart)

Feel free to contact me with any additional questions at 609-642-1442. We look forward to seeing & working with you.

Patrice Matthews - Office Manager

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Initial Patient Information Fact Sheet

Today's Date: _____ Reason for Visit: _____

Personal Information: (Please write clearly)

Patient Legal/Insurance Name: _____

Patient Preferred Name: _____ Pronouns: _____

Address: _____ Home Phone #: _____

City, St & Zip:_____ Cell Phone #: _____

Date of Birth: _____ E-Mail Address:_____

Employer/School Name: _____ Work Phone:_____

Occupation: _____ Length of current employment: _____

Emergency Contact Information:

Name: _____ Relationship: _____ Phone: _____

Insurance Information: *Please provide copy of insurance card.*

Primary Insurance Carrier Name: _____

Secondary Insurance? Yes or No. **If Yes,** please provide a copy of this card as well.

If you are **26 or younger**, list all possible insurance under which you may be covered.

_____ _____

If you are **under 18**, who is your legal guardian_____

DOB of Guardian:_____ Relationship to Patient:_____

First & Last Name of Family Physician: Dr._____

Office Phone Number:_____ Office Fax Number:_____

Patient/Guardian Signature: _____

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Cancellation Policy

I understand that appointments are reservations of the Dietitian's time and range from 30-90 minutes. We ask that you respect our clinician's time and other patients by being on-time for your scheduled appointment. We prevent other patients from reserving your time and we do our best to stay on schedule to respect your time. Therefore, if you do not show up to your scheduled appointment and fail to contact us within 24 hours for Tues-Thurs. or 72 hours for Monday appointments, you will be charged the current session fee for your dietitian for the time you reserved. **You will not be charged if notice is given in a timely manner, at least 24 hours for Tues-Thurs or 72 hours for Monday appointments, in advance of your scheduled appointment.** We know that life happens and we are sensitive to our patient's needs. Please bring the card along with you that matches the following information.

Credit Card Authorization:

( )Visa ( ) Mastercard ( )Discover ( )American Express

Number_____ Expiration Date_____

Three digits from back of card _____ Zip Code:_____

My signature below signifies that I have read, understand, and agree to abide by the above policies, and grant my permission to Integrated Nutrition Therapy, L.L.C. to charge my credit card for any appointment that is not cancelled in the timely manner described above.

Patient/Guardian Signature_____ Date:_____

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Client Responsibilities

1) Be honest about facts, feelings, or ideas that relate to your care.

2) Supply up to date insurance information to Integrated Nutrition Therapy, L.L.C. so we can help determine appropriate benefit coverage.

3) Take an active role in your treatment planning and therapy.

4) Keep scheduled appointments.

5) Report changes in your condition to your clinician.

6) Inform your clinician if you anticipate problems in following your prescribed treatment.

7) Ask for clarification if you do not understand issues related to your care.

8) Honor the confidentiality and privacy of other patients.

9) Communicate concerns and complaints.

10) Meet all financial obligations for services provided, such as co-pays, deductibles, co-insurances or services not covered through insurance, regardless of what benefits were originally quoted.

11) Supply all medical referrals and/or medical authorizations as required by your insurance carrier prior to all appointments.

12) Please provide 24/72 hours notice to cancel or reschedule an appointment. **Failure to do so will result in a session fee per our cancellation policy**

Patient/Guardian Signature:_____**Date:**_____

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Authorization for Insurance Payment and Release of Information

Patient Name:_____

- I authorize payment of medical benefits to Integrated Nutrition Therapy, L.L.C. for services rendered.
- I authorize the release of any medical or other information necessary to process claims for medical benefits.
- ***Insurance is not a guarantee of payment***. The office will make every attempt to validate my coverage and bill my insurance company for my visit. However, I understand that regardless of my insurance coverage, I am responsible for payment of all fees for services rendered to me. If, for ***any reason***, any fees are not paid by my insurance company, I understand that they **must be paid by me** and I am responsible for any outstanding fees.
- I will render co-payments, co-insurance payments, and deductibles at the time of service.
- Once service has been provided, there are no refunds or credits given.
- I am financially responsible for paying Integrated Nutrition Therapy, L.L.C. all amounts my insurance company states are being applied to deductibles, copays, and/ or coinsurance or if my insurance denies benefits.
- I understand that if I make any payments by check that are not cleared by the bank, I will be responsible for repaying such fees in cash or by a valid credit card plus a returned check charge of $35.00.

_____ _____

Patient/Guardian Signature **Date**

ACKNOWLEDGEMENT OF HIPAA NOTICE OF PRIVACY PRACTICES

I have read, acknowledge, and agree to the HIPAA NOTICE OF PRIVACY PRACTICES of Integrated Nutrition Therapy, LLC and am aware that I can view a copy of the policy on file. All requests can be made in writing to: P.O. BOX 3206, Hamilton, N.J. 08619.

Patient/Guardian Signature:_____**Date:**_____