"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*) Home: _____

Email _____

Spouse/Caregiver _____ Permission to speak w this person? YES NO

If patient is a minor, parents' names _____

Primary Care Dr _____ Who referred you to us? _____

Are you here for Bariatric (Weight Loss Surgery) Assessment? YES NO Your Surgeon _____

INSURANCE INFORMATION:

Primary Insurance: _____ ID Number: _____

Who is the Insured ? SELF or _____ DOB _____

Secondary Insurance _____ ID Number: _____

Who is the Insured ? SELF or _____ DOB _____

AM Nutrition Services Policies, please initial each:

_____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 that I received and read the Notice of Health Information Practices. I understand that my healthcare provider participates in Health Current, Arizona's health information exchange (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.

Please sign to acknowledge your understanding and acceptance to comply with our office policies. THANK YOU!

Signature _____ Date _____/_____/2022