

NAME: _____ **DOB:** _____ **GENDER:** male female

By signing below, I acknowledge that I have received the “**Notice of Privacy Practices**” for Pioneer Valley Nutrition, Inc. and I have been provided an opportunity to review it.

Signed: _____ Today's Date: _____

By signing below, I authorize my insurance company to pay the amount due on my pending claim for medical nutrition therapy/diabetes education to Pioneer Valley Nutrition, Inc. I agree I will make payment within 90 days of service if my insurance company has not paid and that it is my responsibility to contact my insurance company for reimbursement if necessary. I am responsible for finding out if my insurance plan pays for services provided by Pioneer Valley Nutrition, Inc. and how many visits to a dietitian they will pay for per year. Co-payments or self-payments are due at time of service. If Pioneer Valley Nutrition, Inc. needs to bill me, I am subject to a \$10 fee. Bad checks are subject to a \$25 fee. I am subject to \$50 fee if I cancel my appointment without 48 hours notice. I will be responsible for the entire cost of the scheduled appointment (\$100.00 for a one-hour appointment and \$60.00 for a ½ hour appointment) if: (1) I do not show up for a scheduled appointment and failed to call in advance to cancel my appointment; or (2) I am tardy to an extent such that Pioneer Valley Nutrition Inc., in its sole discretion, determines it is not possible to provide me with adequate and effective medical nutrition therapy. **ALL FEES MUST BE PAID IN FULL BEFORE WE WILL SCHEDULE YOU A NEW APPOINTMENT.** This policy exists to ensure that all available appointment time is scheduled and that the dietitians are paid for their time.

By signing below, I am stating that I understand all of the information stated in the above paragraph and agree to all of the terms listed.

Signed: _____ Today's Date: _____

CHECK ONE BOX

I permit the Registered Dietitian treating me to discuss my treatment with any healthcare provider who has or is currently treating me.

I permit the Registered Dietitian treating me to discuss my treatment with only the following providers:

I do not wish the Registered Dietitian treating me to discuss my treatment with any of the healthcare providers who have or are currently treating me unless I am a danger to myself or others.

Signed: _____ Today's Date: _____
