20325 N 51st Ave Suite 166
Glendale, AZ 85308
info@uhlingconsulting.com
Phone: 602.341.5248
Fax: 602.702.5219

PATIENT INFORMATION

Patient Name _____ **DOB** _____

Sex _____ **Martial Status** _____ **Social Security #** _____

Address _____

City _____ **State** _____ **Zip Code** _____

Home Phone _____ **Cell Phone** _____

Email _____

Would you like to receive our e-mail newsletter? Circle: Yes No

Referring Physician _____ **Primary Care Physician** _____

INSURANCE INFORMATION

PRIMARY INSURANCE

Policy Holder/Primary Insured Name _____

Patient Relationship To Insured _____ **Date of Birth** _____

Insurance Carrier _____

Subscriber ID# _____ **Group #** _____

Insurance Phone# _____

SECONDARY INSURANCE

Policy Holder/Primary Insured Name _____

Patient Relationship To Insured _____ **Date of Birth** _____

Insurance Carrier _____

Subscriber ID# _____ **Group #** _____

Insurance Phone# _____

EMERGENCY CONTACT INFORMATION

Emergency Contact Name _____ **Relationship** _____

Phone _____ **Address** _____

City _____ **State** _____ **Zip Code** _____

I understand that I am responsible for all charges regardless of insurance coverage. I agree to pay my account with this office in accordance with the regular rates and payment terms within this office. If my account is referred for collection, I agree to pay reasonable collection expenses including attorney's fees.

In the event that I am entitle to health insurance or other benefits relating to my medical condition and it is available to cover the costs of treatment provided by this office, I hereby assign benefits to this office to be applied to my bill.

This office may release records pertaining to my treatment to my insurance company or other third party responsible for payment of my medical bills/charges.

Patient/Parent/Guardian Signature:

_____ **Date** _____

Uhling
Registered Dietitians

20325 N 51st Ave Suite 166
Glendale, AZ 85308
info@uhlingconsulting.com
Phone: 602.341.5248
Fax: 602.702.5219

PATIENT FINANCIAL RESPONSIBILITY AND HIPAA NOTIFICATION

Patient Name _____ **DOB** _____

I. Financial Policy

This is a statement of Uhling Consulting LLC financial policy. You understand that you are obligated to ensure that our fees are paid in full. We will verify your coverage and bill your insurance carrier on your behalf. You agree that you will pay any deductible and co-payment or co-insurance as determined by your insurance plan. Those payments will be due at the time of service. Many insurance companies have additional requirements or stipulations that may affect your coverage. You are responsible for any amounts not covered or payable by your insurance. If your insurance denies any part of your claim, you agree to be responsible to pay the full balance.

II. No Show/Cancellation Policy

Weekday(M-F) Appointments: Uhling Consulting LLC requires a **minimum of 24-hour notice** from our patients when canceling or rescheduling a weekday appointment (Monday - Friday). Failure to cancel/reschedule within 24 hours of your scheduled appointment will result in a **$35 FEE** per infraction. Payment MUST be made prior to scheduling another appointment.

Saturday Appointments: Uhling Consulting LLC requires a **minimum of 24-hour notice** from our patients when canceling or rescheduling a Saturday appointment. Failure to cancel/reschedule within 24 hours of your scheduled appointment will result in **FULL PAYMENT ($125 - initial visit // $75 - follow-up visit)** per infraction**.** Payment MUST be made prior to scheduling another appointment. Saturday appointments are a service we offer to help accommodate patients' schedules.

Telephonic and email appointment reminders are made by our staff when time permits. However, it is ultimately the patient's responsibility to remember scheduled appointments. You may leave notice of cancellations/re-schedules via phone **602.341.5248** or email **office@uhlingconsulting.com**. Please assist us in maintaining good service.

III. HIPAA (Health Insurance Portability and Accountability Act of 1996)

We disclose your protected health information to carry out treatment, payment, and health care operations. If you would like a more detailed description of such uses and disclosures, please refer to the *Notice of Privacy Practices*. You have the right to review the *Notice of Privacy Practices* before signing this consent form. The terms of the *Notice of Privacy Practices* may change from time to time. You can get a copy of the latest *Notice of Privacy Practices* by contacting our office. We also will post a copy of our current *Notice of Privacy Practices* in our office. You have the right to request that we restrict how we use or disclose protected health information to carry out treatment, payment, or health care operations. We do not have to agree to such requests, but must honor the requests to which we agree. You have the right to revoke this consent in writing, and the revocation will become effective except to the extent that we acted in reliance on your consent.

My Acknowledgement

I have read and understand the financial and no show/cancellation policy described above. I agree to pay, promptly and in full, any amounts due to the provider, including co-payments, deductibles, and amounts due for non-covered or services that are not payable by my insurance.

_____ _____

Patient/Parent/Guardian Signature **Date**

_____ _____

Printed Name (if signed on behalf of patient) **Relationship to Patient**