A. Patient Information

Patient Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Home Phone: _____ Cell: _____ Work: _____

Email Address: _____

Date of Birth: _____ ❑ Male ❑ Female

❑ Married ❑ Single ❑ Other

❑ Employed ❑ Full-time Student ❑ Part-time Student ❑ Retired

Relationship to insured: ❑ self ❑ spouse ❑ child ❑ other

Referring Physician: _____

PCP (if diff from above): _____

B. Insured Information (if different from patient)

Insured Name: _____

Street Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____ ❑ Male ❑ Female

C. Insurance Information

Primary Insurance carrier: _____

Insurance ID#: _____ Policy Group #: _____

Type of insurance: ❑ HMO ❑ PPO ❑POS ❑ Medicare Replacement ❑ Other

Secondary Insurance Information (if applicable)

Secondary Insurance carrier: _____

Insurance ID #: _____ Policy Group #: _____

Office Villas of Plantation
140 S. University Drive, Suite D
Plantation, FL 33324
(954) 475-4262

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices for the provider listed above in compliance with the Health Insurance Portability Accountability Act of 1996 (HIPAA).

I will read the notice carefully and if I have any questions or concerns, I will speak with the Privacy Official listed on the first page of the notice.

Today's Date: _____

Individual's Name:
(PLEASE PRINT) _____

Individual's Signature: _____

Address: _____

_____

PATIENT FINANCIAL POLICY

Thank you for choosing Healthy Agendas as your source for Nutrition education and/or diabetes education. We are committed to the success of your well being and long-term good health. Please understand that payment of your bill is part of your treatment and care.

Healthy Agendas is a provider for a number of insurance plans. We make every effort to help determine your insurance benefits in advance, and we will apprise you of your out-or-pocket expense, if any, before service is provided. Ultimately, however, you are responsible for understanding your insurance benefits and securing referrals or prescriptions as needed. As the patent or guardian, you are also responsible for payment if for any reason the insurance claim is refused.

We reserve the right to forward to an outside collection agency any unpaid balances greater than 60 days delinquent.

Your Signature below signifies that you understand the above-stated financial policy and your responsibility regarding charges for services provided.

_____ _____

Patient/Guardian Signature Date

_____ _____

Patient/Guardian (Printed) Date