PATIENT RESPONSIBILITY FORM

IT IS YOUR RESPONSIBILITY TO BE AWARE OF YOUR INSURANCE COVERAGE, POLICY PROVISIONS, EXCLUSIONS AND LIMITATIONS AS WELL AS AUTHORIZATION REQUIREMENTS.

1. INDIVIDUAL'S FINANCIAL RESPONSIBILITY

- I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service.
- Co-payments are due at time of service.
- If my plan requires a referral, I must obtain it prior to my visit.
- In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.
- If I am uninsured, I agree to pay for the medical services rendered to me at time of service.

2. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS

I hereby authorize and direct payment of my medical benefits to *Nutrition HealthWorks LLC* on my behalf for any services furnished to me by the providers. If you have had any changes in your insurance coverage - even if there is only a small change in the co-payment amount or a change in the expiration date of the policy - you must notify us. Even a small discrepancy on the claim form can lead to a claim denial.

3. AUTHORIZATION TO RELEASE RECORDS

I hereby authorize *Nutrition HealthWorks* to release to my insurer, governmental agencies, or any other entity financially responsible for my medical care, all information, including diagnosis and the records of any treatment or examination rendered to me needed to substantiate payment for such medical services as well as information required for precertification, authorization or referral to other medical provider.

Signature of Patient, Authorized Representative or Responsible Party	Date
Print Name of Patient, Authorized Representative or Responsible Party	Relationship to Patient

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