PAYER INFORMATION

Are you covered by a medical insurance plan where you work? ( ) YES ( ) NO
Are you covered by a medical insurance plan form your spouse's employer? ( ) YES ( ) NO
Do you have a Commercial insurance company as your primary insurance? ( ) YES ( ) NO
Is Medicare your primary insurance? ( ) YES ( ) NO
Do you have a secondary insurance other than Medicare? ( ) YES ( ) NO
Do you have a supplemental insurance to your Medicare policy? ( ) YES ( ) NO
Please bring current insurance card to visit with you.

SIGNATURE: ______________________________ **DATE:** ______________

INSURANCE AUTHORIZATION AND ASSIGNMENT

MEDICARE

I certify that the information given to me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize any holder of medical and other information about me to release to the Social Security administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for dietitian services to the organization furnishing the services or authorize such organization to submit a claim to Medicare for payment to me. I request that payment under the medical insurance program be made to Cassara Consulting for services furnished to me.

ALL OTHER INSURANCES

I hereby authorize Cassara Consulting to submit a claim to my insurance carrier or its intermediaries for all covered services rendered by Cassara Consulting and authorize and direct my insurance carrier or its intermediaries to issue payment check(s) directly to Cassara Consulting rendering the covered services. I authorize Cassara Consulting to furnish complete information to my insurance company/carrier or its intermediaries regarding services rendered. I authorize Cassara Consulting to furnish complete information to my referring and consulting physician(s) and my immediate family.

I understand that due to restriction in my coverage (depending on the insurance plan), I may be responsible for services not covered under the plan and it is my responsibility to pay these balances as well as any copayments as applicable.

SIGNATURE: ______________________________ **DATE:** ______________

CANCELLATION/BOUNCED CHECK POLICY

We understand that emergencies occur, however we reserve the right to charge a $25 fee for appointments cancelled without 24 HOURS NOTICE. Furthermore, a no-call, no-show fee of $75 WILL BE charged is an appointment is not cancelled. We reserve the right to charge a fee for bounced checks and YOU ARE RESPONSIBLE for the fee the bank imposes on Cassara Consulting for the bounced check.

COLLECTION AGENCY

If you are delinquent in paying any balance due after receiving multiple notices/invoices from our office, we will forward your information to a collection agency to obtain this balance on our behalf. We reserve the right to charge a fee for accounts sent to collection agencies.

I understand that the aforementioned policies and acknowledge that I am financially responsible for any balance or fees incurred.

SIGNATURE: ______________________________ **DATE:** ______________

Phone: 609-585-8400 1345 Kuser Rd, Suite 5; Hamilton, NJ 08619 Fax: 609-585-8401