Lora Williams, MS, RD, LD
Dietitian
721 N. Locust St.
Denton, TX 76201
(940) 380.8780

INSURANCE AUTHORIZATION, ASSIGNMENT, AND BENEFICIARY NON COVERAGE AGREEMENT

(*Please initial that you have read each and sign below)*

_____ I understand the quote of benefits verified over the phone with a customer service representative prior to my appointment is not a guarantee of payment unless otherwise required by law.

_____ All benefits are subject to the terms, conditions, limitations, and exclusions under the members' policy, including the patient's effective status on the actual date of service.

_____ All necessary forms to bill insurance for professional services rendered will be completed to expedite insurance carrier payments.

_____ If the claim is returned non-payment, all efforts will be made to resolve any reason for non-payment, but if services are not covered, I understand I am responsible for all charges for professional services rendered and I will receive a bill in the event my insurance does not cover services for nutritional counseling, medical nutrition therapy, or diabetic education services by a dietitian.

_____ I understand every effort has been made to verify benefits prior to my appointment. I understand professional services from a dietitian for certain diagnosis codes may not be covered and I may receive a bill. I wish to receive services anyway.

_____ I understand I can appeal any payment denials with my insurance company.

_____ Copayments are due at the time of service.

Insurance Name _____ Specialist CoPay Amount _____

I hereby authorize Lora Williams, MS, RD, LD to bill my insurance for medical nutrition therapy, nutritional counseling, or diabetes education services rendered. I hereby assign to the Dietitian all payments for medical nutrition therapy services and nutrition education classes rendered to myself or my dependents.

I understand that I am responsible for any amount not covered by my insurance due to deductible requirements not met, non coverage of benefits, or benefit exclusions.

I authorize Lora Williams, MS, RD, LD to furnish copies of my medical record maintained by Full Circle Nutrition to my insurance carrier(s) concerning my illness and treatment if requested by my insurance carrier(s).

Signature _____ Date _____

Printed Name _____

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MEDICARE, MEDICAID, and OTHER INSURANCE
Medical Records Release Authorization

I authorize the release of any medical or other information necessary to process a claim to MEDICARE, MEDICAID, TRICARE CHAMPUS, CHAMP VA, GROUP Health Plans, or other insurances. I ALSO REQUEST Payment of government benefits either to myself or to the party who accepts assignment below. (line 12 of CMS 1500 form).

Signed_____ Date_____

Printed Name_____

I Authorize payment of medical benefits to *Lora Williams, MS, RD, LD* for services rendered.
I hereby grant permission to *Lora Williams, MS, RD, LD* to release medical records if requested by CMS for receiving payment for services rendered.

I certify that the information given by me in applying for payment under title XVII and XIX is correct and request that payment be made directly to *Lora Williams, MS, RD, LD* on any unpaid bills for Services rendered to me.

This form constitutes my “signature on file” for line 12 and line 13 of CMS form 1500

Signed_____ Date_____

Printed Name_____

Relationship to Patient:_____ Date:_____