Hello and thank you for choosing LiveWell Nutrition, LLC to assist with your nutrition needs. We are delighted you selected us to help you get on a path towards better health.

This new patient packet contains the following:

- Cancellation/Confirmation policy
- Patient registration form
- Financial Policy
- Privacy practices

Please read through and sign where indicated. Should you have any questions, please contact Shannon Leininger, Owner of LiveWell Nutrition, LLC at 702-508-0630 or shannon@livewellnutritionlv.com.

Cancellation and Confirmation Policy

Confirmation of your appointment is mandatory. Initial calls are made by our automated system and/or sent to you as an email reminder three days in advance. If no response is received from the automated system, you may get additional phone or text reminders from our office staff. Appointments not confirmed by 7:00pm the day before will be cancelled and the patient can reschedule at a more convenient time.

LiveWell Nutrition, LLC asks that you provide at least 24 hours notice for a cancelled appointment. We understand that sometimes things happen, and simply ask that you let us know if you are unable to attend. Our dietitians have only one patient scheduled for each time slot; if you cannot make the appointment please let us know so that we can schedule someone else at that time. You may text or call us at 702-508-0630. A "no call, no show" incident will be charged a $25.00 no show fee. This fee increases to $50.00 for Saturday and Sunday appointments.

By signing below, I acknowledge that I have read and understand LiveWell Nutrition, LLC's cancellation/confirmation policies.

___________________________________ ___________________________________
Print Name of Patient *Print name of Responsible Party*

___________________________________ _______________
Signature of Patient/Responsible Party *Date*

LiveWell NUTRITION
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Patient Registration Form

Patient Last Name: ____________________ Patient first name: _____________________ Middle Initial: ___

Patient Date of Birth: ______________ Social Security Number: ___________________ Sex: Male Female

E-mail: ____________________________ Phone: ________________ Marital Status: S M D W O

Mailing Address: ____________________________________ City, State, Zip: _________________________

Physical Address: ____________________________________ City, State, Zip: _________________________

Employer: ____ Occupation: ____________________________

Referring physician/Primary Care Physician: ____________________________ Phone: ___________________

Responsible Party Information (if someone other than patient)

Name: ____________________________________ Relationship to Patient: ____________________

Address: ____ Phone number: ___________________

Insurance Information

Primary Insurance: __________________________ Responsible Party: _______________________________

Member ID: ________________________________ Group No: ___________ Effective date: ______________

Responsible Party DOB: _______________________ Responsible party SSN: ___________________________

Secondary Insurance: ________________________ Responsible Party: _______________________________

Member ID: ________________________________ Group No: ___________ Effective date: ______________

Responsible Party DOB: _______________________ Responsible party SSN: ___________________________

Emergency Contact

Name: __________________________ Relationship: ______________ Phone number: __________________

Verification of Information Listed Above

Signature of patient/responsible party: _________________________________ Date: _______________

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Financial Policy:

If you are covered by health insurance for Medical Nutrition Therapy benefits, we will be happy to bill your insurance. Please provide us with your current insurance card at the time of each visit and notify us of any changes. We will request a copy of your insurance card to copy and keep on file for our records.

Accepting your insurance does not place all financial responsibilities onto this practice, and you will be held accountable for any unpaid balances by your plan. Your health insurance policy is a contract between you and your health insurance company. You should be knowledgeable of any deductibles, copayments and/or coinsurance.

Although we are contracted with most insurance carriers, our services may not be covered by your particular insurance plan. Being referred to us by your physician does not necessarily guarantee that your insurance will cover our services. Please remember that you are 100% responsible for all charges incurred.

We highly recommend you contact your insurance carrier and ask about your coverage for Medical Nutrition Therapy. Do not assume that you will not owe anything if you have more than one insurance policy. Please note that it is your responsibility to determine if your visits will be covered by your insurance company. If your insurance company does not cover all or part of your bill, you will be financially responsible for the balance.

If your insurance plan sends you a check to pay for services that you received at LiveWell Nutrition, LLC, you are responsible for forwarding the check directly to LiveWell Nutrition, LLC.

If you are uncertain about your current health insurance policy benefits you should contact your plan to learn the details about your benefits, out-of-pocket expenses, deductibles and coverage limits.

Medicare financial policy (applicable only for patients with Medicare)

I request that payment of authorized benefits be made to LiveWell Nutrition, LLC for services rendered to me. I understand my signature requests payment to be made and authorize release of medical information necessary to pay the claim. If other insurance is indicated in box 9a of the CMS 1500 Form, or elsewhere on an electronically submitted claim, my signature authorizes release of the information to the insurer or agency shown. LiveWell Nutrition, LLC agrees to accept the charge determination of my insurance carrier as the full charge and that I, the patient, am financially responsible for the deductible, co-insurance, and non-covered services. Co-insurance and deductibles are based upon the charge determination of my insurance carrier.

Payments
All co-payments and past due balances are due at the time of service. We will bill your insurance. Once they have paid, you will receive a bill for the remaining amount owed. If you have a balance, it is due in full within 30 days of receipt of the statement. If you are unable to pay the full amount within 30 days, please speak with us to arrange payment. Any unpaid balances will be sent to collections after 60 days. We accept cash, checks, and major credit/debit cards. There will be a $30.00 processing fee for any returned checks.

Cash pay policy

If medical nutrition therapy is not a covered benefit of your insurance plan, or we are out of network for your plan, you may opt to pay cash for your visit. Our cash rate is $90.00 per initial visit and $45.00 per follow up visit. We accept cash, check or credit card.

Address Change
It is important that we have your correct address information on file. Please advise us anytime there are any changes to your address, telephone or other contact information.

Assignment of Benefits and Responsibility to Pay
I hereby assign all medical benefits to which I am entitled. I hereby authorize and direct my insurance to issue payment directly to LiveWell Nutrition, LLC for nutrition services to myself and/or my dependents. I have also read and understand the financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice as needed.

By signing below, I acknowledge that I have read and understand LiveWell Nutrition, LLC's financial policies.

___________________________________ ___________________________________
Print Name of Patient *Print name of Responsible Party*

___________________________________ _______________
Signature of Patient/Responsible Party *Date*

Privacy Practices

By signing below, I acknowledge that I have read and understand LiveWell Nutrition, LLC's privacy practices and how my information may be used. I may request a copy for my records.

___________________________________ ___________________________________
Print Name of Patient *Print name of Responsible Party*

___________________________________ _______________
Signature of Patient/Responsible Party *Date*