ISLAND NUTRITION

Client Information, Cancellation Policy and Credit card Authorisation Form (3 pages)

Full name of Patient _____

Male/Female Date of Birth MONTH/DAY/YEAR

Postal address _____

Physical address, if different _____

Phone numbers Cell _____ Home _____ Work _____

Email for reminders and updates _____

Employer _____

Insurance

Provider _____

Group number _____ Policy number _____ Effective date MONTH/DAY/YEAR

Primary insured, if not patient _____ Date of Birth MONTH/DAY/YEAR

Relationship to primary insured Self Spouse Child

Employer of primary insured _____

Address of primary insured _____

Phone number of primary insured _____

Emergency Contact

Name _____ Relationship to client _____

Phone number(s) _____

Physician(s)

General Practitioner _____

Other Physicians and healthcare professionals _____

_____

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Client Medical Information

Full name of Patient _____ Date of Birth MONTH/DAY/YEAR

Please list any medical conditions that you have, or have had previously. Please note if they are current or previous

Please list all medications that you are taking

Please list any allergies you have to foods and medications

Island Nutrition Limited
Tel: 295-4082 Fax: 295-5245 Email: info@islandnutrition.bm
www.islandnutrition.bm

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Island Nutrition strictly enforces a 48 hour cancellation policy. Clients will be charged $150 for a no show and $75 for a late cancellation (less than 48 hours notice)

No shows and late cancellations are a significant problem for our small practice. We make every effort to provide prompt care to all of our patients. If you are unable to keep a scheduled appointment, please let us know **in advance**. We understand that there may be issues beyond your control and want to be understanding of special circumstances.

A **NO SHOW** is when a patient does not show up for their scheduled appointment without contacting the office. A No show will be subject to a **$150 no show fee**.

Appointments which are cancelled with less than 48 hours notice will be subject to a **$75 LATE CANCELLATION fee**. We understand that situations arise in which you must cancel your appointment. It is therefore requested that if you must cancel your appointment you provide more than 48 hours notice. This will enable for another person who is waiting for an appointment to be scheduled in that appointment slot.

If you are delayed and cannot make an appointment on time, please call to advise us of your situation and provide an estimated time of arrival. We may still be able to accommodate you. Any significant delay may require the visit to be rescheduled.

No show and cancellation charges are not covered by your insurance company and are the sole responsibility of the patient.

Please provide a credit card that can be used in the event of a no show or Late Cancellation charge.

Credit card number _ _ _ _ - _ _ _ _ - _ _ _ _ - _ _ _ _ Expiry date ____/____ (MMYY) Verification code _____

This information will be held securely and only used if necessary for these charges.

Our practice firmly believes that good provider/patient relationship is based upon understanding and good communication. Please provide an up to date email address and cell phone number that we may use for appointment reminders and updates. It is your responsibility to update your contact details should they change. Please note you should not rely on our reminder system and you are responsible for remembering your appointments.

Email address: _____

Cell number: _____

I HAVE READ, UNDERSTAND AND AGREE TO THIS CANCELLATION AND NO SHOW POLICY.

I AGREE TO ASSUME RESPONSIBILITY FOR ALL CHARGES. I AGREE THAT ALL AGENCY CHARGES, LEGAL COSTS AND OTHER EXPENSES INCURRED IN ATTEMPTING TO RECOVER OVERDUE AMOUNTS, WILL BE CHARGED TO THIS ACCOUNT.

I AUTHORISE THE RELEASE OF ANY MEDICAL INFORMATION NECESSARY TO PROCESS MEDICAL CLAIMS AND LIAISE WITH OTHER HEALTHCARE PROVIDERS.

PRINT NAME: _____ SIGN: _____ DATE: _____

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