ISLAND NUTRITION

Client Information, Insurance and Consent Form (4 pages)

Client Information

Full name of Patient/Client _____

Male/Female Date of Birth (Please write out month e.g. FEB) MONTH/DAY/YEAR

Postal address _____

Physical address, if different _____

Phone numbers Cell _____ Home _____ Work _____

Email for reminders and updates _____

Employer _____

Emergency Contact

Name _____ Relationship to client _____

Phone number(s) _____

Parent(s)/Guardian(s) Information, if child

1. Full name of Parent/Guardian _____

Date of Birth MONTH/DAY/YEAR Relationship to client _____

Phone numbers Cell _____ Home _____ Work _____

Email address _____

Employer _____

2. Full name of Parent/Guardian _____

Date of Birth MONTH/DAY/YEAR Relationship to client _____

Phone numbers Cell _____ Home _____ Work _____

Email address _____

Employer _____

ISLAND NUTRITION

Health Insurance

Please note: Island Nutrition will submit health claims on behalf of clients directly to their health insurer. It is your responsibility to provide us with accurate information and to update your insurance details should they change. Any copays or claims denials are the responsibility of the client or their guarantor.

*** If you have a HIP/SHB policy as well as a supplementary policy, please provide the details for your HIP/SHB policy.*

Health Insurance Information

Full name of client as it appears on insurance card _____

Date of Birth MONTH/DAY/YEAR

Health Insurance Provider _____

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

Please have your health insurance card to hand so we may take a copy

Policy Holder Information (if not the client)

Full name of policy holder, if not client _____

Male/Female Date of Birth MONTH/DAY/YEAR Client relationship to policy holder Spouse Child

Email address of policy holder _____

Employer of policy holder _____

Guarantor Information (Individual with financial responsibility for any fees incurred)

☐ Patient/Client is responsible. ☐ Policyholder listed above is guarantor. ☐ Other (please provide details below)

Full name of Guarantor _____

Male/Female Date of Birth MONTH/DAY/YEAR

Phone numbers Cell _____ Home _____ Work _____

Email address _____

Employer _____

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Client Medical Information

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

Reason for Referral/What is your primary concern:

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/or medications:

Please list all Physicians you see including your General Practitioner, Specialist Physicians and all other Healthcare Professionals:

Registered Dietitians; Improving access to high quality nutritional care
Tel 295-4082 | Fax 295-5245 | Dallas Building, 7 Victoria Street, Hamilton. HM11 | www.islandnutrition.bm
For appointment & patient enquiries: reception@islandnutrition.bm | Managing Director, Hannah Jones: info@islandnutrition.bm

ISLAND NUTRITION

Cancellation and No Show Policy

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

Island Nutrition strictly enforces a 48-hour cancellation policy.

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 clients. 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 client 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 or rescheduled to a different day 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 or change your appointment. It is requested that if you must cancel or change your appointment you provide at least 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 client or their guarantor. Payment of cancellation and no show fees are due immediately.

Communication

Our practice firmly believes that good provider/client relationship is based upon understanding and good communication. We may use the email address and/or cell phone number provided to send 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.

Health Insurance Benefits

Island Nutrition will submit health claims on behalf of clients directly to their health insurer. Health claim forms require specific client information to be submitted in order for the health insurer to process claims. It is your responsibility to update your insurance details should they change. Any copays or claims denials are the responsibility of the client or their guarantor. Copays and client balances are due at the time of service.

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

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

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

PRINT NAME: _____ SIGN: _____ DATE: _____

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