Nutrition
Patient Information

Please complete the forms below. Once completed, please email them to **Info@KarenRaden.com**

Patient's legal name_____

Preferred name_____ Gender _____ Date of birth ____/____/____

Home address_____

City_____ State_____ Zip_____

Email address_____ Fax #_____

Home #_____ Work #_____ Cell #_____

Which number do you prefer to be called by our office?_____

Can confidential medical information be left on this number's voicemail? Yes _____

If patient is under 18, please fill info below:

Guardian's name_____ Date of birth_____/_____/_____

Home address_____

City_____ State_____ Zip_____

Email address_____ Fax #_____

Home #_____ Work #_____ Cell #_____

Which number do you prefer to be called by our office?_____

Can confidential medical information be left on this number's voicemail?_____

EMERGENCY INFORMATION

Authority is given to contact the following person in the case of an emergency:

Name_____ Relationship_____

Home #_____ Work #_____ Cell #_____

INSURANCE INFORMATION

Insurance company_____

Group #_____ Identification # _____

Name of primary insured _____

Relationship to patient_____ Birth date of primary insured_____/_____/_____

Whom may we thank for referring you? _____

I authorize the release of any information concerning my healthcare, or my child's healthcare (if applicable), advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits . In lieu of payments which would otherwise be payable to me, I hereby authorize payments directly to the doctor.

Signature_____ Date_____/_____/_____

Print Name_____

HIPAA Patient Consent Form

I understand that, under the Health Insurance Portability and Accountability act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to :

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers
- Conduct normal healthcare operations such as quality assessments and physician certifications

I have been informed by you or your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address listed on this form to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name_____

Signature_____

Relationship to patient_____

Date_____/_____/_____

542 Lincoln Avenue, Winnetka, Il 90093

Karen Raden Nutrition
Financial Policy Effective November 2023

1. It is our pleasure to process each and every insurance claim through our billing department, however, it is your responsibility to verify coverage prior to your appointment. Not all insurance plans cover all nutrition services. The fact that an insurance plan may not pay for a particular service does not mean that you should not receive it. In the event that your insurance provider determines a service to be “not covered,” you will be responsible for the complete charge. To facilitate a claim, a copy of your driver's license and insurance card will be required. If you would like to check for nutrition coverage, you can contact your insurance provider and ask if Dr. Roma Franzia is in your insurance plan. Then ask if you are covered by a registered dietitian and have nutrition coverage.

Initials_____

2. Co-payment is due at time of service.

Initials_____

3. Self-pay Patients: Payment is due on the day of the appointment. Kindly refer to the “Fees for Service” price list.

Initials_____

4. Out of network provider: if your insurance company does not have a contract with Roma Franzia Pediatric Practice, you are considered to be out-of-network. You will be responsible for the out-of-network balance owed.

Initials_____

5. Cancellation: An appointment must be canceled at least 24 hours in advance or a fee of $150 will be charged to the credit card on file.

Initials_____

6. No Show: If a scheduled appointment results in a **“No Show,” a fee of $150** will be charged to the credit card on file.

Initials_____

7. Speaking with a registered dietitian during office hours: A simple conversation with a registered dietitian during office hours is free, A medical decision making conversation requiring documentation, is a “Tele" charge that will be billed to your insurance company which will result in a co-pay/balance that you will be responsible to pay. Most insurance companies have allowed for this charge due to medical/legal responsibility.

Initials_____

8 Speaking/texting/emailing with a Dietitian after office hours: A telephone/text call will be responded to by a dietitian as soon as possible. Emails will be answered the next day. A “Tele” charge will be billed to your insurance company which will result in a co-pay that you will be

responsible to pay. Most insurance companies have allowed for this charge due to medical/legal responsibility.

Initials_____

9 Outstanding Balances: Once an insurance claim is processed, you will receive a statement. If a balance on your statement is due, payment must be made within 30 days. Failure to pay the balance in full within 30 days of the statement date will result in a late charge of 1.5%. Late charges will accrue monthly until the remaining balance is paid. If you are experiencing financial hardship, please contact our billing specialist, Ritu, at (224) 365-8401 or email: Ritu@DrRomaFranzia.com to make payment arrangements. Initials_____

I, _____(name of responsible payer), authorize and request my insurance company to pay directly to Dr. Franzia's Pediatric Practice my insurance benefits otherwise payable to me. I agree to be responsible for payment of all services rendered on my behalf or my dependent(s).

I have read and understand Dr. Roma Franzia's Pediatric Practice Financial Policy.

Signature_____

Print Name_____ Date_____

Credit Card Payment

After a charge is processed, a receipt will be given or mailed to you.

This credit card information will be entered into our Electronic Medical Records System and then shredded for security. Only the last 4 digits of this card will be available to our practice.

Method of Payment ◯ **Mastercard** ◯ **Visa** ◯ **Discover** ◯ **American Express**

Credit Card Number_____

Expiration Date_____CVV Code_____

Signature_____

Print Name_____

Date_____

Once completed, please email to **Info@KarenRaden.com**