901 Buccaneer Dr. N
Glenview, IL 60026
Ph (847) 724-8015
Fax (847)728-8221

This is a **REQUIRED** form.
This ENTIRE form must be completed BEFORE your first appointment will begin.

Name:
DOB:

Below you will find detailed information regarding your rights and responsibilities and established policies of this practice. Please read this carefully and select the checkbox at the end of each section if you agree. Please feel free to ask any questions for clarification:

Agreement to Use Electronic Signatures and Electronic Documents

I agree that the electronic signatures included in this notice are intended to authenticate this writing and to have the same force and effect as manual signatures.

Electronic signature means any electronic sound, symbol, or process attached to or logically associated with a record and executed and adopted by a party with the intent to sign such record, including (without limitation) typing a name or clicking a checkbox.

I agree to use electronic documents, notices, and contacts "electronic documents", for all future transactions and communications. Electronic documents contain the same information as paper documents, notices, and contracts. Paper documents, notices, and contracts are available at my request. If I give my consent to use electronic documents, I can later change your mind and request a paper agreement instead.

I agree:

Cancellation Policy

I agree to keep all scheduled appointments and be on time. If I cannot attend a scheduled session, I will contact Feed to Succeed, LLC to cancel and/or reschedule. Late arrivals of up to 15 minutes may be seen *upon request* of the family, but the appointment block will be shortened to end at the scheduled end time. There will be no fee if the appointment is canceled before 24 hours of the scheduled appointment time. I understand if I miss or cancel with less than 24 hours of notice, then my credit card will be charged a $180 fee for the appointment. If my credit card is unable to be billed, I agree to pay the balance on my statement within 10 days of receipt.

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I agree:

Informed Consent for Telehealth Consultations

I understand that telehealth is the use of electronic information and communication technologies by a healthcare provider for the delivery of services to an individual when he/she is located at a different site than the provider. I hereby consent to Feed to Succeed, LLC providing healthcare services to me via telehealth.

I understand that the laws that protect the privacy and the confidentiality of health information also apply to telehealth. Feed to Succeed, LLC's telehealth services are provided by Kalix, Inc., a HIPAA compliant EMR and telehealth platform.

Kalix's telehealth platform uses a secure browser-to-browser technology without the need to download or install any software. All data, video, audio, and files are encrypted in both transit and rest. Telehealth appointments are not recorded in any way, but I understand that I have the right to access any information resulting from the service, as required by law.

To join a telehealth appointment, Feed to Succeed, LLC will send me a secure link and code as part of my appointment confirmation and appointment reminder messages, which are sent through email or text message. For more information, click here.

I understand that telehealth services are not the same as direct in-person appointment delivery because I will not be in the same room as the healthcare provider. The inability to have direct, physical contact with my healthcare provider is a primary difference between telehealth and direct in-person service delivery.

I understand there are potential risks to this technology, including interruptions and technical difficulties. I understand that Feed to Succeed, LLC or I can discontinue the telehealth appointment if it is felt that the telehealth connections are not adequate for the situation. Good internet download and upload speed is required for quality telehealth services. The recommended minimum upload and download speeds required is 2Mbps. I can conduct an internet speed test by clicking here. I understand that the quality of my video connection may affect the quality of services provided by Feed to Succeed, LLC.

I have had the alternatives to telehealth services explained to me, and I understand that my use of this technology is voluntary. I have the right to withhold or withdraw my consent to use telehealth in the course of my care at any time, without affecting my right to future care or treatment. I may revoke my consent orally or in writing at any time by contacting Feed to Succeed, LLC. As long as this consent is in force (has not been revoked), Feed to Succeed, LLC may provide healthcare services to me via telehealth without the need for me to sign another consent form.

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Financial Policy

I understand that I am obligated to ensure that our fees are paid in full. Feed to Succeed, LLC will verify my coverage and bill my insurance carrier on my behalf. However, I am ultimately responsible for the payment of my bill. I understand that it ***is my responsibility to inquire with my insurance*** to determine my specific benefit exclusions for “Medical Nutrition Therapy”, billed under codes 97802 and 97803.

I agree that I will pay any deductible and co-payment or co-insurance as determined by my insurance plan. Those payments will be due at the time of service. Many insurance companies have additional requirements or stipulations that may affect my coverage. I am responsible for any amounts not covered or payable by my insurance. If my insurance denies any part of my claim, I agree to be responsible to pay the full balance. If I choose not to keep a credit card on file to pay balances, I understand that Feed to Succeed, LLC may decline to bill my insurance on my behalf.

I agree:

Signature on File Authorization

By signing this statement, I am authorizing to complete any necessary insurance claim forms on my behalf. I am also authorizing the release of any medical or other information which may be needed in order to process my claims.

My signature will be kept on file and shall be referred to when insurance claim forms are submitted for healthcare services I have received.

Note: if you are incapable of signing, or are under the age of 18, a parent or legal guardian must sign in your place.

Insured's Signature

Date of birth:
Insurance card ID number:

Credit Card Authorization Form

It is our policy for ***all*** patients to keep a valid credit card on file. Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until canceled.

I understand that Feed to Succeed, LLC will submit all patient visits first to insurance to attempt to obtain coverage for my/my child’s nutrition visits. I authorize Feed to Succeed to charge my credit card for all co-pays, co-insurances, deductibles, missed appointment fees and unpaid visits at the credit card listed below.

I, , authorize Feed to Succeed, LLC to charge my credit card. I understand that my information will be saved to file for future transactions on my account.

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You may choose to decline this credit card authorization by calling the office at (847) 742-8015. In the event that you decline to authorize a credit card for balances, you must set up and pay for all visits in-full at the time of service. In lieu of us submitting to your insurance, we will provide you with a Superbill to pursue insurance coverage on your own behalf.

I agree:

HIPAA Privacy Policies

- Notice of Privacy Practices (HIPAA).pdf

I agree:

Consent to Treatment

I have read through all the above information and have been clearly advised of my rights and responsibilities as a client of Feed to Succeed, LLC, including the HIPAA Notice of Privacy Practices.

I understand these rights and responsibilities and agree to abide by them. I consent to treatment, and I understand I have a right to receive a copy of this form upon request. I also understand that I can withdraw this consent in writing and terminate it at any time.

I agree:

Signature

Please sign below if you agree to all policies described above.

I certify that I am the of and that I do have legal custody of . I accept the above agreements on the behalf of my child.

I agree: