901 Buccaneer Drive North
Glenview, IL 60026
Office 847-724-8015
www.feedtosucceed.com
info@feedtosucceed.com

Intake & Registration Information

Patient Information

Child's Name_____
Date of Birth_____ Sex at Birth: Male Female
Contact Phone _____
Address_____
City_____State_____Zip_____

Parent/Guardian Information

Primary Contact Name_____
Contact Phone _____ Email _____
Address_____
City_____State_____Zip_____

Secondary Contact Name_____
Contact Phone _____ Email _____
Address_____
City_____State_____Zip_____

Parent/Guardian Marital Status: _____ Patient Primarily Living With: _____

Medical Information:

Primary Care Physician _____ Phone # _____
Name of Practice_____ Fax # _____

Insurance Information

Insurance Company_____
Address_____
City_____State_____Zip_____
Name of policy holder_____ Relationship to patient_____
Policy holder's birthdate_____ Employer_____
Policy #_____Group #_____
****Insurance is filed by this office as a courtesy to the patient. However, the patient is responsible for all fees, regardless of insurance coverage. It is the patient/parent's responsibility to be aware of their benefits coverage.****

_____
Signature Relationship to patient Date

Office Use Only: _____Policies _____Insurance Card _____Credit Card _____Release

Version 2.0 effective date 2-15-2020, Feed to Succeed, LLC

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Patient's Name: _____ Patient DOB: _____

The undersigned, by providing his/her signature and initials in the space below, agrees to accept the therapy services provided by Feed to Succeed, LLC ("F2S") in accordance with and pursuant to the terms and conditions set forth herein on the detailed documents provided below.

Please initial in the box and sign the bottom of the page

☐ I have read and received a copy of F2S's Patient Services Acknowledgement & Agreement and in agreement with what is outlined

☐ I have read and received a copy of F2S's Cancellation and Late Arrival Policy and in agreement with what is outlined

☐ I have read and received a copy of F2S's HIPPA and Privacy Practice and Notice of Individual Rights and in agreement with what is outlined

☐ I have read and received a copy of F2S's General Waiver and Release for Parents or Legal Guardians of Patients and in agreement with what is outlined

☐ I have read and agreed to the terms of payments as outlined on the Credit Card Authorization Form

☐ I have provided F2S with a copy of my insurance card and agree to notify them if any changes occur with insurance

_____

Parent/Guardian Signature Date

All of the above-mentioned documents are below, were included in your initial confirmation email and are included on the Feed to Succeed website.

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Credit Card Authorization Form

This credit card /debit authorization form is our way of ensuring that regular and prompt payments are received per the determined billing method as outlined in the Patient Services Acknowledgment & Agreement form. We accept Visa, MasterCard, Discover, and American Express.

☐ Please send me a bill for outstanding balances to the address on file. I understand that the prompt payment discount of 25% will no longer apply if my payment is received 30 days after the billing date on patient statement. I am aware that a $10 late fee per month applies for all outstanding balances. If balance is not paid within 90 days of patient statement date, the credit card listed below will be charged.

☐ Please charge the credit card listed below for any outstanding balance, which may include services not covered by insurance, copays, coinsurance, deductible, cancellation fees, etc. A copy of the paid balance will be emailed to the primary email address on file.

Please note our Cancellation Policy

There will be a $25.00 charge for appointments missed or cancelled with less than 24-hours notice.

Please print clearly below.

Patient's Name: _____ DOB: _____

Name on Credit Card: _____

Visa® MasterCard® Discover® American Express®

Credit card number: _____

Expiration date: _____ CVV/CSV: _____

Credit Card billing address and zip code: _____

_____

I hereby authorize Feed to Succeed, LLC, Inc. to charge the above credit card based on selection above for the amount due according to Feed to Succeed, LLC's billing policies, in compliance with the obligations set forth in the Cardholder agreement with the issuer:

Cardholder's Name in Print:_____

Cardholder's Signature: _____

Date: _____

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Consent for Release of Information

Child's name: _____DOB:_____

I hereby authorize F2S to contact the health care providers set forth below and obtain from those providers all information relating to my child (written or otherwise) which, in the opinion of F2S, will assist F2S in their evaluation and treatment of my child. Such information may include, without limitation, "individually identifiable health information" as defined and provided in the Health Insurance Portability and Accountability Act. In addition, I hereby authorize F2S to share reports and "Feedback on Results" with the professionals listed below including those obtained by caregivers, educators, or relatives involved in your child's care.

Provider Name: _____**Phone #:** _____

Title: Pediatrician Fax progress report: YES NO

Provider Name: _____**Phone #:** _____

Title: Fax progress report: YES NO

Provider Name: _____**Phone #:** _____

Title: Fax progress report: YES NO

Provider Name: _____**Phone #:** _____

Title: Fax progress report: YES NO

Parent/Guardian's Signature: _____

Relationship to child: _____ **Date:** _____

Signature of Child (ages 12 yrs. and older) _____

(In accordance with The Mental Health and Developmental Disabilities Confidentiality Act)

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PATIENT SERVICES ACKNOWLEDGMENT & AGREEMENT

We at F2S are committed to providing the best treatment possible for all our patients and we charge what is usual and customary for our area. Feed to Succeed, LLC is an in-network provider with select insurance carriers. It is your responsibility to inquire with your insurance to determine if F2S is a participating provider and to verify your benefits for "Medical Nutrition Therapy", billed under codes 97802 and 97803.

All information on the attached "Insurance Information" documents must be completed. If incomplete or a copy of your current insurance ID card is not on file we will be lacking the minimum required information to generate a claim and the responsibility for payment then becomes that of the insured.

Please be advised that services rendered may be considered "non-covered" by insurance. Non-covered services are not considered medically necessary and are not reimbursable by insurance. F2S will work with the insurance company on claims where medical documentation is required.

IN-NETWORK PATIENTS:

F2S charges what is usual and customary to our region as determined by both insurance carrier and other providers in our area.

To expedite your child's care, claims will be submitted to carriers F2S is contracted with and any payment issued will be received by F2S.

F2S cannot guarantee the coverage of services, therefore, any deductibles, co-pays, or co-insurances will be the responsibility of the patient.

Claims that are denied and therefore become 100% responsibility of the patient are eligible for a 25% discount for prompt payment received within 30 days of date on patient statement. Discounts cannot be applied to deductibles, co-pays & co-insurance.

Payment for services is due in full within 30 days of date on patient statement. Unpaid balances more than 90 days old will automatically be billed to your credit card on file.

It is our policy for all our patients to keep a credit card on file.

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OUT-OF-NETWORK PATIENTS:

Acquisition of any authorizations or referrals required for services from the insurance carrier or primary care physician will be the patient's responsibility.

Referrals not on file with F2S at the time of service may render the patient responsible for 100% of the billed fees.

As a courtesy, F2S will file all claims on the patient's behalf to the indicated insurance carrier. Claims that are denied and therefore become 100% responsibility of the patient are eligible for a 25% discount for prompt payment received within 30 days of the date on patient statement. Discounts cannot be applied to deductibles, co-pays & co-insurance.

Payment for services is due in full within 30 days of date on your patient statement. Unpaid balances more than 90 days old will automatically be billed to the credit card on file.

It is our policy for all our patients to keep a credit card on file.

FEES (IN AND OUT-OF-NETWORK):

Medical nutrition therapy (MNT) will have a fee of $300 that will be submitted to your insurance for up to a 60-minute initial evaluation*. Additional time will be billed in 15-minute increments if needed, at a rate of $75 per 15 minutes.

Additional MNT sessions will be billed at $150/session to your insurance* for up to a 30-minute visit. Additional time will be billed in 15-minute increments if needed, at a rate of $75 per 15 minutes.

Ongoing (follow up) MNT sessions will be billed at $150/session* for a 30-minute visit. Additional time will be billed in 15-minute increments if needed, at a rate of $75/15 minutes.

Ongoing patients or patients who return for a visit after 12 months or longer has passed since the initial evaluation, will require an annual 1-hour reassessment as needed, to be determined by your service provider and based upon time of $75/15 minute increment.

* *All fees pertaining to treatment and evaluations performed by F2S shall be deemed fully earned and payable upon the providing of such service. All outstanding balances remaining unpaid more than 30 days after receipt shall accrue a service fee of $10 per month in addition to the outstanding balance.* ***ANY AND ALL FEES CHARGED BY F2S ARE SUBJECT TO CHANGE AT THE SOLE DISCRETION OF F2S UPON PRIOR NOTICE TO THE UNDERSIGNED.***

☐ This copy of F2S's Patient Services Acknowledgement & Agreement policy is the patient's copy. You agreed to these terms by initialing and signing our policy form.

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CANCELLATION AND LATE ARRIVAL POLICY:

Our dietitians reserve time slots especially for your child. Please arrive 10 minutes before your scheduled appointment time. Late arrivals of up to 15 minutes will be seen upon request of the family, but the appointment block will be shortened to end at the scheduled end time. This keeps our therapists on schedule and prevents other patients from excessive wait times. If you are more than 15 minutes late, you will be asked to reschedule your appointment and you will be charged $25 for a missed appointment.

In order to help us provide you and other patients with the highest level of service, we request that you provide 24-hour notice for appointment changes and cancellations. This allows us to schedule you and other patients in an efficient way and prevents dead time to your service provider (which in turn helps us manage our childcare and other personal situations effectively).

There is a $25.00 charge for appointments canceled, changed or missed with less than 24-hour notice.

If you fail to show up to a home visit appointment and a service provider comes out to your home, you will be billed for the full fee of the visit plus the home visit fee of $100 to compensate us for our time, travel, and childcare.

As fellow parents, we thank you for your understanding and consideration.

RIGHT TO REFUSE SERVICE:

F2S reserves the right to refuse service to any patient in the event of any delinquent or unpaid fees for services performed without any liability or further obligation to the undersigned.

ENFORCEMENT:

The undersigned acknowledges and agrees to reimburse F2S for all fees and expenses, including, without limitation, any attorney's fees and expenses, incurred by F2S in enforcing any terms or provisions hereof, including, without limitation, the collection of fees for services provided. Checks returned for insufficient funds incur a $25 processing fee.

The undersigned is solely and directly responsible for the full payment of all fees charged by F2S regardless of any insurance coverage afforded to the undersigned. We will electronically submit your claims after each session and your insurance company will process the claims according to your benefits.

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Notice of Privacy Practices and Notice of Individual Rights

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. Please review it carefully.

YOUR HEALTH INFORMATION

1) This notice describes information about privacy practices followed by our employees, staff and other practice personnel.
2) This notice applies to the information and records we have about your health, health status, and the healthcare and services you receive from our practice.
3) We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU.

We must have your written, signed consent to use and disclose health information for the following purposes:

- For Treatment. We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to doctors, nurses, technicians, practice staff, or other personnel who are involved in taking care of you and your health. Different personnel in our practice may share information about you and disclose information to people who do not work in our practice in order to coordinate your care, such as phoning other care providers, meeting with other care providers, and providing reports as requested to other care providers
- For Payment. We may use and disclose health information about you so that the treatment and services you receive from our practice may be billed to and payment may be collected from you, an insurance company, or a third party. For example, we may need to give your health plan information about a service you received so that you health plan will pay us or reimburse you for the service. We may also tell your health plan about a treatment you are going to receive to obtain prior approval to determine whether your plan will cover the treatment.
- Appointment Reminders. We may contact you as a reminder that you have an appointment for treatment or care either in our office or at your home.

You may revoke your consent at any time by giving us written notice. Your revocation will be effective when we receive it, but it will not apply to any uses and disclosures that occurred before that time.
If you do revoke your consent, we will not be permitted to use of disclose information for purposes of treatment, payment or healthcare operations, and we may therefore choose to discontinue providing you with healthcare treatment and services.

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SPECIAL SITUATIONS

We may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:

- To Avert a Serious Threat to Health or Safety. We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the heath and safety of the public or another person.
- Required by Law. We will disclose health information about you when required to do so by federal state or local law.
- Research. We may use and disclose health information about you for research projects that are subject to a special approval process. We will ask for your permission if the researcher will have access to your name, address or other information that reveals who you are, or will be involved in your care at the office.
- Public Health Risks. We may disclose health information about you for public health reasons in order to prevent or control disease, injury or disability; or to report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.
- Lawsuits and Disputes. If you are involved in a lawsuit or dispute, we may disclose health information about you in response to a court or administrative order. Subject to all applicable legal requirements, we may also disclose health information about you in response to a subpoena.
- Law Enforcement. We may release health information if asked to do so by law enforcement officials in response to a court order, subpoena, warrant, summons or similar process, subject to all the applicable legal requirements.
- Information Not Personally Identifiable. We may use or disclose health information about you in a way that does not personally identify you or reveal who you are.
- Family and Friends. We may disclose health information about you to your family members or friends if we obtain your verbal agreement to do so or if we give you an opportunity to object to such a disclosure and you do not raise any objection.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

You have the following rights regarding health information we maintain about you.

- Right to Inspect and Copy. You have the right to inspect and copy your health information, such as medical and billing records, that we use to make decisions about your care. You must submit a written request in order to inspect and/or copy you r health information. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other associated supplies. We may deny your request to inspect and/or copy in certain limited circumstances. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, we will select a licensed healthcare professional to review your request and our denial. The person conducting the review will not be the person who denied your request and we will comply with the outcome of the review.

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- Right to Amend. If you believe the health information we have about you is incorrect or incomplete, you may ask us to amend that information. You have the right to request an amendment as long as the information is kept by this office.
- Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or healthcare operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for it, like a family member or friend. For example, you could ask that we not use or disclose information about surgery you had.
- We are Not Required to Agree to Your Request. If we do agree, we will comply with your request unless the information is needed to provide you emergency treatment.
- Right to request confidential communications. You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

CHANGES TO THIS NOTICE

We reserve the right to change this notice and to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. You are entitled to a copy of the notice currently in effect.

☐ This copy of F2S's HIPPA and Privacy Practice and Notice of Individual Rights policy is the patient's copy. You agreed to these terms by initialing and signing our policy form.

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GENERAL WAIVER AND RELEASE FOR PARENTS OR LEGAL GUARDIANS OF PATIENTS

I, _____, the parent or legal guardian of _____ (hereinafter "Patient"), with the birth date of _____ on behalf of myself and Patient, have authorized Feed to Succeed, LLC ("F2S") to provide Patient and family with medical nutrition therapy. I voluntarily consent to the professional recommendations, evaluations and/or treatment offered by F2S. I acknowledge that neither F2S nor any of its agents have made any guaranty or promise to me about the results of these therapy services. I further acknowledge and agree that the success of such therapy services greatly depends on Patient's and parents' and/or guardians' level of commitment, motivation and adherence to the advice or suggestions given during therapy and, how more generally, Patient responds to the therapy, and for these reasons, F2S cannot guarantee the outcome of any procedures or treatment. I understand my right to know all treatment purposes, risks, benefits and alternatives, and I acknowledge and understand that I will be given ample opportunity to ask any questions of F2S regarding any and all of these issues or matters before any such procedures or treatment is provided.

Consistent with the above, I, on behalf of myself and Patient, **waive, release and hold harmless** F2S, any related entities, its Board of Directors, shareholders, officers, employees, volunteers, agents and any independent contractors (hereinafter "the Released Parties") from any and all claims, costs, suits, actions, judgments and expenses, for or involving damage, loss or injury to Patient or Patient's property, arising out of Patient's participation in F2S's therapy services or related treatment. I understand that this General Waiver and Release is intended to be as broad and as inclusive as permitted by the laws of the state of Illinois and agree that if any portion of this General Waiver and Release is held invalid, the remainder of this General Waiver and Release will continue in full legal force and effect.

I affirm that I am of legal age and am freely signing this General Waiver and Release on behalf of myself and Patient. I have read this General Waiver and Release and fully understand that by signing below, I am giving up legal rights and/or remedies which may be available to me or Patient for injury or damage to Patient or Patient's property, arising as a result of Patient receiving therapy services by F2S, whenever, or however the same may occur. I further acknowledge and agree that I was informed that I have the right to consult with an attorney before signing this General Waiver and Release and that this sentence shall constitute written notice of the right to be advised by legal counsel.

I fully acknowledge and agree that this General Waiver and Release sets forth all of the terms and conditions of the agreement between the Parties concerning the subject matter hereof, and it supersedes any and all prior and/or contemporaneous agreements, understandings and communications, whether oral or otherwise, regarding such matters. This General Waiver and Release shall be construed and interpreted in accordance with the internal laws of the State of Illinois. Once this General Waiver and Release becomes effective, its terms can only be altered, revoked or rescinded with the express written agreement of both of the Parties.

I declare that the foregoing is true and correct, and that it has been signed on this _____ day of _____, 20_____.

☐ This copy of F2S's General Waiver and Release for Parents or Legal Guardians of Patients policy is the patient's copy. You agreed to these terms by initialing and signing our policy form.