901 Buccaneer Drive North
Glenview IL, 60026
Office: (847) 724-8015
E-mail: info@feedtosucceed.com
www.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

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Credit Card Authorization Form – Update Effective 8/1/2022

We accept Visa, MasterCard, Discover, and American Express. It is our policy for all our patients to keep a credit card on file.

I understand that Feed to Succeed 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, and unpaid visits at the credit card listed below.

Please note our Cancellation Policy

There will be an $80.00 charge for all new appointments missed or canceled with less than 24-hour's notice. There will be a $40.00 charge for follow-up appointments missed or canceled with less than 24-hour's 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: ____________________________

☐ *I decline the discount for prompt payment. Please send me a bill for outstanding balances to the address on file. I understand that the prompt payment discount of 25% will not by applied for services and I will be charged the full fee of $80 per 15-minute increment. I am aware that a $10 late fee per month applies for all outstanding balances. If my balance is not paid within 60 days of patient statement date, the credit card listed below will be charged.*

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PATIENT SERVICES ACKNOWLEDGMENT & AGREEMENT – UPDATE EFFECTIVE 8/1/2022

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 if patient/patient family consents to have outstanding balances billed directly to a credit card on file. 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 60 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 if patient/patient family consents to have outstanding balances billed directly to a credit card on file. 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 60 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 $320 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 $80 per 15 minutes.***

Ongoing (follow up) MNT sessions will be billed at $160/session* for a 30-minute visit.
Additional time will be billed in 15-minute increments if needed, at a rate of $80/15 minutes.

Ongoing patients or patients who return for a visit after 12 months or longer has passed since the initial evaluation, may require an annual 1-hour reassessment, to be determined by your service provider and based upon time of $80/15 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.***

Patient Name: ____ DOB _____________________

Parent/Guardian Name:_________________________Sign: _________________________
Date: __________

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CANCELATION AND LATE ARRIVAL POLICY: UPDATE EFFECTIVE 8/1/2022

Our dietitians reserve time slots especially for your child. ***Please arrive 10 minutes before*** your reserved 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 $80 for a new, and $40 for a follow-up missed appointment.

To help us provide you and other patients with the highest level of service, we require that you provide 24-hour notice for appointment changes and cancelations. This allows us to schedule you and other patients in an efficient way and prevents dead time to your service provider.

There is an $80.00 charge for new appointments canceled, changed or missed with less than 24-hour notice. There is a $40.00 charge for follow-up appointments canceled, changed or missed with less than 24-hour notice.

To reserve your first appointment, we require a credit card to hold your reservation. Be advised that your credit card will not be billed at the time you book the appointment reservation. However, if you do not show up for your first appointment or if you cancel with less than 24 hours notification, you are subject to the cancelation policy defined above and your credit card will be charged $80 per new patient and $40 per follow up patient.

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.

Patient Name: ____ DOB: ________________________________

Parent/Guardian Name: ________________________Sign: ___________________________ 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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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.

- 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.

Patient Name: ____ DOB: ________________________

Parent/Guardian Signature: ____