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Release for Coordination with Health Insurance Company for Billing

Patient name (printed) _____Birthday_____

Patient address _____

Patient phone number(s) _____

Name of health insurance company _____

Address and phone number of Health Insurance Company _____

_____

ID/Policy number _____

For the purpose of direct reimbursement for medical nutrition therapy, my dietitian has my permission to exchange with my health insurance company pertinent information about me and my appointments, including: number of appointments, diagnoses, and treatments. I hereby authorize the use or disclosure of individually identifiable health information and appointment information for billing purposes. This release shall be valid until 365 days after my last date of treatment or until the time I revoke this release, which can be done at any time.

Patient signature_____

or Patient representative's signature (if applicable) _____

Date_____

If you do not wish any information to be exchanged with your health insurance company, please sign below.

I do NOT give permission to the practitioner named above to exchange information with my health insurance company, I agree to pay for medical nutrition therapy on my own. My dietitian will provide a Superbill for me to seek insurance reimbursement on my own.

Patient or patient representative's signature _____

Date _____