Michelle Konstantarakis Jensen
MS, RDN, LD, CDE

REGISTERED DIETITIANS & NUTRITIONISTS
CREATING A NEW NORM

702.475.4007 Office
702.475.4060 Fax
www.creatinganewnorm.com

6040 South Fort Apache Road, Suite 100
Las Vegas, NV 89148

3277 East Warm Springs Road Suite 300
Las Vegas, NV 89120

PATIENT INFORMATION

Last Name	First Name	Middle Initial

Mailing Address	City	State	Zip Code

Physical Address	City	State	Zip Code

Primary Phone	Secondary Phone	Message OK?

Email Address	Dietitian Contact/Reminders?
	☐ Yes ☐ No

Check One: ☐ Male ☐ Female Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Date of Birth	Age	Social Security Number

Employer	Occupation

Referring Physician or Current Primary Care Physician	

RESPONSIBLE PARTY (IF SOMEONE OTHER THAN THE PATIENT)

Name	Primary Phone	Secondary Phone

Address	City	State	Zip Code

Relationship to Patient	

INSURANCE INFORMATION

Primary Insurance Information		Secondary Insurance Information	
Insurance Company		Insurance Company	
Policy Holder Name		Policy Holder Name	
Date of Birth		Date of Birth	
	☐ Male ☐ Female		☐ Male ☐ Female
Policy Number		Policy Number	
Group Number	Effective Date	Group Number	Effective Date

Emergency Contact Person			
Relationship		Phone	

By signing below, I have read and understand the financial agreement and recognize that I am financially responsible for all charges, whether or not they are paid by insurance. I hereby authorize the doctor to release all necessary information to secure the payment of benefits.

Patient/Responsible Party Signature: _____

Relationship to Patient: _____

Date: _____

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WELCOME

Thank you for selecting Creating a New Norm to help you create a new 'lifestyle'. We are committed to providing you with the highest quality care and achieving desired outcomes through a collaborative effort with you, the patient. Your clear understanding of our Patient Financial Policy is an essential element of your care and treatment. Please ask if you have any questions about our fees, our polices, or your responsibilities. Carefully review the following information and return this form to us with your signature and today's date.

FINANCIAL POLICY / PAYMENT OPTIONS

INSURANCE

It is the patient's responsibility to provide Creating a New Norm with accurate insurance information. We will ask for your insurance card at your first visit to obtain a copy for our records. If current and accurate information is not obtained at the time of service, it will become the patient's responsibility to pay until current and accurate information is provided to the office. Not all services provided to you are always covered by your insurance. Some insurance companies arbitrarily select certain services that they will not cover. You are responsible for all services not covered by your insurance. _____(Initial)

Insurance is a contract between you and your insurance carrier. It is your responsibility to check with your insurance company for your benefits. _____(Initial)

PARTICIPATING PLANS

If Creating a New Norm participates with your insurance plan, we will bill your insurance plan for the fees associated with the services that you receive. After 60 (sixty) days any remaining balance may become your responsibility whether or not your insurance company has made payment. _____(Initial)

NON-PARTICIPATING PLANS

The providers at Creating a New Norm do not all participate in every plan. It is your responsibility to check with your insurance company and see if we are a participating provider with your plan. If we do not participate in your insurance plan, you may still choose to be seen by the practice. If your plan has out-of-network benefits, your insurance plan may pay for a percentage of the fees for the services that you receive. Payment is expected in full at the time of service, however as a courtesy to you, we will file a claim with your insurance carrier on your behalf. If you do not pay in full, any remaining balance will be billed to you once we have received a remittance from your insurance carrier. If your insurance plan sends you a check to pay for services that you received at Creating a New Norm, you are responsible for forwarding the check directly to Creating a New Norm. _____(Initial)

CO-PAYS
It is Creating a New Norm's policy that co-payments, co-insurance and/or deductibles are not waived. You are responsible for the payment of co-pays, co-insurance and/or deductibles that are required by your insurance plan. Such fees will either be collected at the time of your visit or you will receive a bill from us in the mail. _____(Initial)

SELF PAY ACCOUNTS
Patients without insurance and/or patients without an insurance card on file at the time of service and patients who have not met their insurance plan deductible are expected to pay at the time of service. _____(Initial)

MEDICARE
I request that payment of authorized benefits be made to Creating a New Norm, LLC for services rendered to me. I understand my signature requests payment to be made and authorize release of medical information necessary to pay the claim. If other insurance is indicated in box 9a of the CMS 1500 Form, or elsewhere on an electronically submitted claim, my signature authorizes release of the information to the insurer or agency shown. Creating a New Norm, LLC agrees to accept the charge determination of my insurance carrier as the full charge and that I, the patient, am financially responsible for the deductible, co-insurance, and non-covered services. Co-insurance and deductibles are based upon the charge determination of my insurance carrier. _____(Initial)

MEDICAID AND ANTHEM BCBS MEDICAID
In the event a Medicaid insured individual exceeds the maximum allowed amount of services during a specified period of time as indicated by the patient's insurance company, the patient will be held financially responsible for any services rendered as a result of the patient exceeding the maximum allowed services. Should the patient have questions regarding the maximum allowed number of services or amount of time allowed, it will be the responsibility of the patient to contact Medicaid, as Creating a New Norm staff and providers do not keep track of patient benefits, including if the patient has met or exceeded the allowed amount of service types rendered to the patient. _____(Initial)

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PAST DUE ACCOUNTS

Balances not collected at the time of services will be billed to you on a monthly basis. We realize that temporary financial problems may affect timely payment of your account. If such problems do arise, we encourage you to contact us promptly for assistance in managing your account. Past due accounts are subject to collection proceedings. All fees including, but not limited to collection fees, attorney fees and court fees shall become your responsibility in addition to the balance due this office. _____(Initial)

Thank you for understanding our financial policy. If you have any questions regarding your bill or the status of your account, please call the business office at 702.475.4007.

PATIENT FINANCIAL RESPONSIBILITY AGREEMENT

I have read and understand the financial policy of Creating a New Norm and I agree to be bound by its terms. I also understand and agree that such terms may be amended from time to time by the practice.

By signing below, I acknowledge that I have read, understand and accept this Financial Policy and I agree to make payment for any co-payments, co-insurance and/or deductibles that are required by my insurance plan. Additionally, I agree to send you any checks that I receive from my insurance plan for services that I received at Creating a New Norm.

_____	_____
Print Name of Patient	Print Name of Responsible Party
_____	_____
Signature of Responsible Party	Date Signed

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OFFICE POLICIES

"NO SHOW" POLICY

Appointment Reminder Preference

Cell Phone_____OR Home Phone_____with message machine.

Automated courtesy confirmations start arriving a week before an appointment and require your response. It is your responsibility to provide us with current telephone numbers. This is done by our office as a courtesy, please be responsible for your appointments.

Failure to give 24-hour notice of cancellation prior to your appointment or not showing up for your appointment can result in a charge of $50 on your account. This charge cannot be billed to the insurance company and will be your responsibility. In addition, missing two or more appointments may result in discharge from our practice. _____(Initial)

PAYMENTS

Payments for services rendered are due at the time of service unless prior arrangements have been made.

Overdue balances need to be paid before your next appointment.

An additional monthly fee may be charged on past due accounts and co-pays not rendered at time of services.

We accept cash, check and credit card. A fee of $30.00 will be charged for checks returned for insufficient funds. You may be placed on a "cash only" basis upon any return checks._____(Initial)

CONSENT

In addition, I also give consent to Creating a New Norm to disclose my protected healthcare information to the following person and/or people:

_____

Name Relationship

_____

Name Relationship

I have read and understand the listed policies.

Signature:_____Date: _____

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Privacy Notice - HIPAA

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED. PLEASE REVIEW IT CAREFULLY!

Registered Dietitians and office personnel at **Creating a New Norm** make it a priority to protect information that is personal and private. We are required by law to follow the procedures in this Notice. The Health Insurance Portability and Accountability Act (HIPAA) law sets rules and limits on who can look at and receive your health information. To make sure that your health information is protected in a way that does not interfere with your health care, your information can be used and shared *without* your written authorization for the following purposes:

FOR TREATMENT: Creating a New Norm may share information with your other designated treatment providers including, doctors, nurses, therapists, and treatment facilities involved in your care for any/ all of the following: coordination of care; care quality improvement; case management; customer service evaluation/improvement.

FOR PAYMENT & HEALTH INSURANCE BILLING: Creating a New Norm may use and disclose protected health information for individuals in our care to verify insurance coverage and for insurance billing (that may include a third party). Your insurance company may require a clinical assessment(s) to determine eligibility and approval for treatment.

FOR YOUR SAFETY (AS REQUIRED BY STATE LAW): Creating a New Norm may disclose protected health information about you to a public health or legal authority to prevent a serious threat to your health and safety.

We will obtain your written authorization before using or disclosing your protected health information for purposes other than the reasons listed above (or as otherwise permitted or required by law). You may amend and/or revoke this authorization in writing at any time stating specific exclusions or restrictions. Upon receipt of the already written revocation, we will stop using or disclosing your information, except to the extent that we have already taken action in reliance on the authorization.

CHANGES TO THE TERMS AND NOTICE

Creating a New Norm can change the terms of this notice, and the changes will apply to all information we have regarding our patients. The new notice will be available upon request, in our office.

I understand and agree this document will remain in effect for all future dietitian office visits to Creating a New Norm, unless specifically rescinded in writing by me. A copy of this document shall be as valid as an original.

If you have any questions about this notice, please contact: **Michelle Konstantarakis Jensen MS, RDN, LD, CDE, Owner and Licensed Dietitian for Creating a New Norm at 702.475.4007**.

I acknowledge receipt of this Notice of Privacy Practices.

Printed:_____

Signature:_____ Date: _____

To Learn more about Health Information Privacy:
www.hhs.gov/ocr/privacy/hipaa/understanding/index.html