Alka Sheth, MS, RDN

Premier Nutrition Services, Inc., 2 Hunt Ct, West Windsor, NJ 08550

PATIENT RESPONSIBILITY FORM (v1.6)

Patient Name: ____

Name of Person Financially Responsible (“Responsible Person”): ______________________________

1. **Financial Responsibility**
   - **a.** I/Responsible Person understand that I am/Responsible Person is financially responsible for my health insurance deductible, coinsurance, and any service not covered or paid by my insurance carrier. Co-payments are due at time of service.
   - **b.** If my plan requires a referral, I will obtain it and provide it to us prior to my visit.
   - **c.** In the event that my health insurance plan determines a service to be “not payable” for any reason whatsoever, or if I am uninsured, I/Responsible Person agree to promptly pay all charges for the nutritional counseling services provided to me as stated in 1f below.
   - **d.** If my insurance company has told us that they will fully/partially cover the nutritional counseling services provided and if we have communicated the same to you, I/Responsible Person understand that the insurance company may still determine to not pay the claim for any reason whatsoever. In that event, I/Responsible Person agree to promptly pay all the charges, as stated in 1f below, for the nutritional counseling services.
   - **e.** I/Responsible person understand that Alka Sheth or Premier Nutrition Services will **not** check my benefits.
   - **f.** **I/Responsible person understand that if I/Responsible person is not insured or if the insurance company does not pay us, I/Responsible Person will promptly pay the out-of-pocket charges of $150 for first visit and $99 for each follow-up visit/ follow-up call.**
2. **Insurance authorization for Assignment of Benefits**
   - **a.** I hereby authorize and direct Medicare and insurance companies for payment of my medical benefits to Alka Sheth or Premier Nutrition Services, Inc. on my behalf for any nutritional counseling services furnished to me by the providers.
3. **Authorization Release Records**
   - **a.** I hereby authorize Alka Sheth and Premier Nutrition Services, Inc. to release to my insurer, government agencies, or any other entity financially responsible for my medical care, all information including diagnosis and the records of any treatment or examination provided to me and needed to substantiate payment for such nutritional counseling services or required for pre-certification, authorization or referral.

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Signature of Patient, Authorized Representative or Responsible Person **Date**

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Print Name of Person Signing This Form **Date**