

To prepare for your Nutrition visit with the Registered Dietitian:

Using Insurance

You must check insurance coverage before coming in for your appointment. Even if you have an **excellent** insurance policy **it does not mean** you have coverage for nutritional services. To verify your nutrition coverage please call the 800 number on the back of your card and ask to speak with a representative from member services. The provider for the visit is **Dima Salhoobi, RD**. Please ask the representative the following questions:

1. Do I have **nutrition services** on my current insurance policy?
2. Is my **diagnosis** covered? [You can get this diagnosis from your doctor]
3. **How many** covered visits do I have per calendar year?
4. What is considered a **calendar year** for my current policy?
5. Do I have a **co-pay** or **deductible** for nutrition services?

You will be asked to pay any applicable co-pays and/or deductibles **at the time of your visit**. You will also sign a liability waiver stating that you will be responsible for the charges if your insurance does not cover the visit.

→ **Note - Your RD will be taking a credit card number at your first visit. In the event your claim gets denied by your insurance company (or if you have an outstanding co-pay/deductible) your credit card will be charged for the visit.**

The initial visit \$165.00 and last around 1 hour and 15 minutes. Each follow up lasts around 30 minutes and costs \$80.00. Therefore, please make sure to verify your insurance PRIOR to your visit. We assume no responsibility for the verification of your benefits.

What insurance companies do you participate with?

At the present time we are **in-network-providers** with:

Medicare (Diabetes and Renal Disease [stage IV or V] diagnosis ONLY)

Cigna

Aetna

**Humana
Emblem**

What happens if you participate with my provider – but when I called the insurance company they told me I have a yearly deductible I have not met?

In the event you have a deductible we will not be able to initially bill your insurance company directly. Therefore, payment of \$150.00 is due at the initial visit and \$80.00 is due at each follow up visit. We will provide you with the appropriate documentation to submit to your insurance company to show receipt of the services. This will allow you to “pay down” your deductible. Once your deductible has been met and you have nutrition services on your policy, we can then directly bill your insurance company.

What happens if I have an insurance that you do not participate with?

In the event you carry insurance that we are considered **out of network (Oxford, United..etc)** for you will need to **pay** for your counseling session at **the time of service**. We are happy to provide you with a “Superbill” and/or an itemized invoice you can submit to your insurance company for reimbursement. Reimbursement is based on your policy’s standards. Please call your insurance company’s member services number to verify how reimbursement works under your current insurance policy.

What forms of payment do you accept?

We accept cash, check or charge. Please make checks payable to FRESH Nutrition counseling Corp. Due to the fact that we are not MD’s – we cannot accept Health Saving Account (HSA’s) debit or credit cards.

Where are you located?

Our address is **2025 central park ave, STE 2A**. We are located in the same building top floor of Optimum physical therapy.

Is there anything I should do to prepare for my nutrition visit?

1. Verify your insurance benefits with your insurance company
2. Fill out the ***Patient Demographics-Insurance*** sheet **PRIOR** to your visit and bring with you. This form is located on page 4 of this document.
3. Be prepared to provide a credit card which will be kept on file in a safe, secure locked location. Your credit will only be charged in the event there is a problem processing your claim. Note we cannot accept FLEX Benefits card.
4. Please carefully read the ***New Patient Liability Form***. Please initial each paragraph, fill in your credit card information and sign/date acknowledge you agree with the information stated in the document. This form is located on page 5 of this document.
5. Please call us with any questions (914-4263896)

New Patient Liability Form

Please read carefully. Once you have read and understand the information please sign your initials in the space after each paragraph as well as sign and date at the bottom of the page.

Payment:

Payment is expected at the time of your appointment. If you have a co-pay you will be asked to pay it at the beginning of your visit. We accept cash, check or credit card. Checks are to be made payable to FRESH Nutrition counseling Corp. We do not accept FLEX benefit cards.

The cost for all initial visits is \$150.00. The cost for each follow-up visit is \$80.00 ____

Appointment:

Individual appointments are scheduled for a specific time. We run on time and expect you to as well. In the event you cannot make your scheduled appointment we kindly ask you provide a 24 hour advance notice. **You will be charged \$30.00 for appointments not cancelled within 24 hours.** ____

Medical Insurance:

Medical insurance companies may or may not offer coverage for outpatient nutrition counseling. It is important for the client to carefully investigate the types of coverage you may have. The client assumes 100 % responsibility for verifying their nutrition benefits with their insurance company. _____

Credit Card:

For anyone desiring to use health insurance for their nutrition benefit a **credit card number is required.** Patients will not be seen without ALL of requested information. Your credit card will **ONLY** be charged in the event **your claim is rejected or you do not cancel your appointment within 24 hours.** Please provide your information below.

Type of Credit Card _____

Credit Card Number _____

Expiration Date _____

CV _____

I, hereby ensure that the above information is true and correct, and recognize the responsibility for payment of nutrition counseling services. I understand that my credit card above will be charged in the event my insurance company denies the claim or does not pay the charge in full for my session for

whatever reason. I also understand that my credit card will be charged for appointments not cancelled or changed within 24 hour prior to the scheduled time of the appointment.

Signature of responsible party: _____

Date: _____