



# Personalized Nutrition For The Whole You SIMPLICITY NUTRITION

**PLEASE NOTE ALL 3 AREAS MUST BE SIGNED IN ORDER FOR OUR OFFICE TO BE ABLE TO BILL YOUR INSURANCE COMPANY**



## **AUTHORIZATION TO BILL INSURANCE**

I, \_\_\_\_\_, hereby give my consent for **SIMPLICITY NUTRITION, INC.** to bill my insurance company (INSURANCE PROVIDER) \_\_\_\_\_ for services rendered to me by the above mentioned health care provider.

PATIENT SIGNATURE: \_\_\_\_\_

## **ASSIGNMENT OF BENEFIT**

I authorize the above mentioned insurance company to pay medical benefits directly to the above mentioned health care provider.

PATIENT SIGNATURE: \_\_\_\_\_

## **AUTHORIZATION TO RELEASE MEDICAL INFORMATION**

I authorize, SIMPLICITY NUTRITION, INC to release necessary medical information to the above mentioned insurance company and/or to their designated managed care company LIBERTY BILLING, LLC, as is required by my insurance company to process my insurance claims.

I understand that my express consent is required to release any health care information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/mental health, or drug and/or alcohol use. You are specifically authorized to release all health care information relating to such diagnosis, testing, or treatment.

Date: \_\_\_\_\_ PATIENT SIGNATURE: \_\_\_\_\_

SS#: \_\_\_\_\_ DOB: \_\_\_\_\_