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

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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.

Patient signature: _____

Date: _____ DOB: _____