N S C W M
north shore center
for weight management
www.nscwm.com

NEW PATIENT INFORMATION

Date_____.

Name_____

Address_____

Phone Number (easiest to reach you) _____

Email Address _____.

INSURANCE:

Company Name_____

Phone Number_____

Claims Address_____.

Insurance ID Number_____

Group Number_____

Employer_____

Spouse Employer (if necessary) _____

Date of Birth_____

Spouse Date of Birth (if necessary) _____

707 Skokie Boulevard • Suite 600 • Northbrook, IL 60062 • 847.509.7560 (phone) • 847.509.7562 (fax)

N S C W M
north shore center
for weight management
www.nscwm.com

Policies for North Shore Center for Weight Management

Consent for Treatment
I hereby authorize, and acknowledge to work with, North Shore Center for Weight Management to administer treatment as may be deemed necessary for the interest and care of me (the client) as described on this form.

Assignment of Insurance Benefits and Payment Information
I authorize insurance payment to be made directly to North Shore Center for Weight Management. I authorize North Shore Center for Weight Management to release any information about me to insurance carriers needed to process claims. I understand that I am responsible for all charges not covered by my insurance plan. I understand that the responsibility of the account balance is the client's, not the insurance company's.

Delinquent Accounts
I understand that any account balance which is 60 days past due will be paid in full. Should insurance payment occur at a later date, the balance can be applied to the account or refunded.

Twenty-four hour Cancellation
I understand the appointment time between the client and practitioner is a reserved one. Unless cancellation ***is made twenty-four hours in advance*** the ***client*** will be responsible for the ***full charge*** of the time reserved, except when specified by the practitioner. ***Please be informed that insurance carriers will not reimburse for missed sessions, making the charge the client's responsibility.***

Signature

_____ _____
Name of Client Date

_____ _____
Signature Relationship to Client

_____
Witness

N S C W M
north shore center
for weight management
www.nscwm.com

Consent to Release Information

I hereby give my consent to release information from:

North Shore Center for Weight Management

And to provide to:

_____	_____
Name of Person or Facility	Address

I hereby give my consent to release information from:

_____	_____
Name of Person or Facility	Address

And provide to:

North Shore Center for Weight Management

I understand this release covers any necessary records and/or verbal information. I also understand I may revoke this consent at any time.

_____	_____
Client's Name	Client's Signature
_____	_____
Client's Birth Date	Date
_____	_____
Witness	Signature of Guardian

707 Skokie Boulevard • Suite 600 • Northbrook, IL 60062 • 847.509.7560 (phone) • 847.509.7562 (fax)