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On Track Nutrition & Fitness Consulting

3479 Preddy Creek Road

Charlottesville, VA 22911

434-227-0774

ontrack26@gmail.com

NEW PATIENT INTAKE FORM/APPOINTMENT & PAYMENT POLICY

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 (Date)

Patient name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Parent/guardian (if applicable) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Billing Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Home Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Work Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of birth \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency contact \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Therapist \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical Doctor\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Psychiatrist\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Appointment Policy**

1. Patients are expected to be on time for all appointments. If you know you will be late, please call. In order to keep schedules running on time, patients who are late may not receive their full session time.
2. When canceling, please give 24-hours notice. If you do not, this shall be considered a missed appointment and will be charged as such (even if we are able to reschedule your appointment for a different date/time). In the event of an emergency, in which you cannot provide 24-hour notice, I will use discretion on a case-by-case basis.
3. It is patient’s responsibility to contact the insurance company, obtain any necessary pre-authorization, and receive any estimation of benefits. Patient receipts will be made available by request, and it is patient’s responsibility to submit any/all insurance forms for potential reimbursement.
4. Response to pertinent (treatment related) emails and phone calls will be charged on a cumulative basis in 15min increments (when session equivalent is met you will be charged accordingly).
* Initial Consult, nutrition or training (60 min.) $240
* Follow Up, nutrition or training (40 min.) $190
* Personalized Menu or Exercise Plan $90
* Loved One Forum/Support Group $40
* Phone & Email Consults (cumulative hourly rates as above)
* \*Checks payable to Katherine Bruno.
* \*Appointments: Cancelled/Missed Without 24-Hrs Notice are Subject to Payment.
* \*$25 Service Charge For Returned Checks.
* \*Potential insurance reimbursement facilitated by patient.
* \*$25 late fee per overdue month.
* \*In the case of delinquency, all attorney/collection fees paid by patient.

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**Payment Policy**

**Method of Payment (select one), receipts emailed at any interval upon request:**

**☐ Cash, Check (paid at appointment or upon receipt of statement), please use credit card for missed/late cancel/unpaid appts only**

**☐ PayPal to ontrack26@gmail.com, Venmo to @Kate-Bruno-68, or Zelle (paid at time of service or upon receipt of statement), please use credit card for missed/late cancel/unpaid appts only**

**☐ Credit Card - Please automatically charge my credit card on file whenever billing payment is due**

**Credit Card Info:**

 **Card number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Expiration: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**CVV (3 or 4 digit code on back): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Zip code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Cell or email for receipt: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ,**

 **(Print Name)**

**Have read and agree to the above Appointment/Payment Policy & waive any professional/personal liability on the part of Kate Bruno/On Track Nutrition.**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient’s signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Parent or Guardian (if patient under 18) Date