*Release of Benefits*

***Pyramid Nutrition Services, Inc***

***33 Mulberry Street 14 South Westfield St 77 Mill St Ste 233***

***Springfield, MA 01105 Feeding Hills, MA 01030 Westfield, MA 01085***

***Phone: 413-330-8167 Fax: 413-480-0517***

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Phone #:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State:\_\_\_\_\_\_\_\_\_ Zip Code:\_\_\_\_\_\_\_\_\_ Date of Birth:\_\_\_\_\_\_\_\_\_

**Authorization, Release and Assignment of Benefits:**

In consideration of your undertaking to provide nutrition counseling, I agree to the following:

1. I authorize payment of any medical benefit to be made solely payable and sent directly to Pyramid Nutrition Services, Inc.
2. In the event that deductible is not met or insurance does not cover services, I agree to pay for services in full.
3. A photocopy of the Authorization and Assignment will be considered as effective and valid as the original.

**Notice of Privacy Practices**

**Effective April 1, 2004**

I acknowledge that I have received Pyramid Nutrition Services Notice of Privacy Practices.

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

Authorizing Signature Date

I acknowledge no call/no show fee of $40. I take responsibility to keep appointment or notify of need to reschedule/cancel at least 24 hours prior to appointment even if confirmation is not received.

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

Authorizing Signature Date

I acknowledge authorization, release and assignment of benefits.

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

Authorizing Signature Witness

**Consent to Treat a Minor**

I hereby authorize the staff of Pyramid Nutrition Services to administer treatment within their scope of practice as they deem necessary for \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

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

Name of Parent/Legal Guardian Signature of Parent/Legal Guardian Date