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Patient Name

Insurance Liability Waivers

I understand that it is my responsibility to provide the most recent and proper medical insurance information to my health care providers. I understand that it is my responsibility to insure that an insurance referral to a specialty care provider is current. I understand that I may be held personally responsible for any medical service provided to me for which the most recent and proper insurance information is not given at the time of a service if my deductible has not been met.

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Patient Signature

Date

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Guardian Signature

Date

I understand that in the usual course of business, Medical Nutrition Therapy might not normally be covered by my insurance company. I, therefore, understand that should the provider, Southeast Clinical Nutrition Centers, Inc. be unable to collect fees from my insurance company for services provided, I will be responsible for those fees incurred.

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Patient Signature

Date

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Guardian Signature

Date

Assignment of Benefits

I hereby authorize payment directly to: SOUTHEAST CLINICAL NUTRITION CENTERS, INC of Insurance benefits herein specified and otherwise payable to me, but not to exceed the regular charges for this period of admission/service. I understand that I am financially responsible to SOUTHEAST CLINICAL NUTRITION CENTERS, INC for any charges not covered by this authorization. I permit a copy of this authorization to be used in place of the original.

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Patient Signature

Date

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Guardian Signature

Date