

TODAY'S DATE: \_\_\_\_\_

**PATIENT INTAKE INFORMATION:**

Patient's Full Name: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_ Email: \_\_\_\_\_

Home/Cell Phone: \_\_\_\_\_ Work: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**Please initial if we do not have permission to leave a voicemail**

Marital Status: \_\_\_\_\_ Social security Number: \_\_\_\_\_

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

Referred by: \_\_\_\_\_

**RESPONSIBLE PARTY INFORMATION (If different from above):**

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

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

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

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

**INSURANCE INFORMATION:**

**If you would like your insurance billed for you, the following information *must be complete*.**

Primary Insurance Company: \_\_\_\_\_ Address: \_\_\_\_\_

Employer: \_\_\_\_\_

Subscriber's Name: \_\_\_\_\_ Date of birth: \_\_\_\_\_

**Policy Number:** \_\_\_\_\_ **Group Number:** \_\_\_\_\_

Does your coverage include Naturopathic Care? Y N **\*Our office does not bill secondary insurances\***  
(unless primary & secondary are same company)

**Emergency Information: Person(s) to contact in case of emergency:**

Name: \_\_\_\_\_ City/State: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ City/State: \_\_\_\_\_ Phone: \_\_\_\_\_

WE WILL BILL **PRIMARY MEDICAL INSURANCE** FOR YOU AT **NO CHARGE**. IF YOU CHOOSE TO PAY FOR YOUR VISIT UP FRONT, WE WILL ENDEAVOR TO HELP YOU IN ANY REASONABLE MANNER TO OBTAIN REIMBURSEMENT FROM YOUR INSURANCE COMPANY; HOWEVER OUR RELATIONSHIP IS PRIMARILY WITH YOU AND OUR STATEMENTS WILL GO DIRECTLY TO YOU AT ALL TIMES. IF YOU ANTICIPATE DIFFICULTY WITH PAYMENT, PLEASE CONTACT OUR OFFICE. IF THE PROBLEM FOR WHICH YOU ARE SEEING US INVOLVES LITIGATION, SUCH AS AUTO ACCIDENT, PLEASE BE ADVISED THAT WE DO NOT WAIT FOR PAYMENT UNTIL LITIGATION IS SETTLED, BUT WILL EXPECT REGULAR MONTHLY PAYMENTS ON THE ACCOUNT. **\*\*Insurance Non-Payment Policy: AFTER 90 DAYS OF NON-PAYMENT FROM YOUR INSURANCE COMPANY, THE BALANCE ON YOUR ACCOUNT WILL BE TRANSFERRED TO YOUR RESPONSIBILITY.\*\***

**PATIENT'S SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_  
(OR CUSTODIAN OF PATIENT)

<b>PATIENT POLICIES</b>
-------------------------

**PAYMENT** - Payment for all **orthopedic supplies, lab fees and supplements** are due and **payable at the time of service**. Patients without insurance pay in full at the time of service. Most blood tests are paid for at the time of service or are billed to your insurance company. If you do not have insurance, blood tests must be paid for at the time of service. Our office accepts Visa and MasterCard, cash and personal checks. **Please call 24 hours in advance to cancel an appointment**. If you do not call to cancel, you will be billed a \$25 cancellation/no show fee. If you provide a credit card upon scheduling, it will be billed the same day the appointment is missed.

**INSURANCE** - If you carry insurance coverage, the insurance contract is between you and your insurance company. It is your responsibility to see that charges are promptly paid. As a courtesy to you, we bill your insurance for you. **We require you to make co-pay or required percentage payments at the time of service.**

**LITIGATION** - Patients involved in law suits are, as others, responsible for timely payments of charges incurred.

**WORKER'S COMPENSATION** - Patients filing worker's compensation claims (on-the-job) do not pay for services directly related to the accident or illness. The employer's insurance carrier is billed weekly. It is your responsibility to record dates of services and mileage to and from A Family Healing Center in order to apply for mileage allowance. We recommend you keep a daily log of expenses and symptoms.

**REINSTATED CARE** - Unless you are under current care in this office (within the past six months) an examination may be necessary to reinstate proper treatment. Each new injury or chief complaint requires an examination due to the possibility of structural changes or a change in diagnosis.

**PERSONAL HYGIENE** - For health considerations and due to the close interpersonal nature of our work, your personal cleanliness is required for a comfortable environment. **NO SMOKING** or other strong aromatics please.

I have read and understand the notice of privacy policies of A Family Healing Center.

I understand that insurance may not cover certain diagnostic tests, IV Therapy, or supplements that may be prescribed by the doctor and I agree to pay for these costs at the time of visit.

I have read the policies above and agree to be financially responsible for services provided by this office.

**My signature is an acknowledgement that I have read the policies above and agree to abide by them.**

**PATIENT SIGNATURE** \_\_\_\_\_ **DATE** \_\_\_\_\_

If the patient is a minor, permission is given by me to the doctors of this office to treat my child.