NEW CLIENT REGISTRATION - PLEASE PRINT ALL REQUESTED INFORMATION CLEARLY

PATIENT LEGAL NAME ____________________ DATE OF BIRTH __________ AGE ______

GENDER: □MALE □FEMALE HEIGHT ________ WEIGHT ________ MARITAL STATUS: □MARRIED □SINGLE □WIDOWED □DIVORCED

ADDRESS ____________ CITY ____________ STATE ____________ ZIP ____________

OCCUPATION ____________________ EMPLOYER ____________________

( )__________ HOME PHONE ( )__________ CELL PHONE ( )__________EXT:________ WORK PHONE

PARENT/GUARDIAN/LEGALLY RESPONSIBLE PARTY NAME (IF APPLICABLE) ____________________ RELATIONSHIP ____________________

EMERGENCY CONTACT NAME____________________ PHONE: ( )__________

HOW DID YOU HEAR ABOUT THE SPRINGS? ____________________

IF YOU WOULD LIKE TO RECEIVE EMAILS FROM THE SPRINGS, WE SEND – APPOINTMENT *REMINDERS, NEWS, EDUCATIONAL ARTICLES, SALES & PROMOTIONS VIA EMAIL.* *You may choose to unsubscribe at any time and your information will never be sold or shared with any other list.*

EMAIL: ____________________

ACKNOWLEDGEMENT OF FINANCIAL POLICIES

By signing below, I acknowledge that I understand the following policies:

- I will be required to **provide credit card information** to hold appointment times, **or prepay** for the scheduled service. You may pay for the service in any format you choose. We accept cash, checks, all major credit cards, and Spa Finder Gift Certificates.
- **Late Cancellation Policy:** Any late cancellation will incur a charge of 50% of the full session fee. We require 24 hours notice for single appointments & require a minimum of 48 hours notice to cancel or reschedule without incurring the 50% fee. Exceptions to the late cancellation policy may be granted at the discretion of the manager.
- **No Show Policy:** No shows will be charged 100% of the service fee for the scheduled appointments missed.
- There is a $15 fee for returned checks.
- Payment is due at the time of treatment.
- I will be responsible for full payment for my service, even if I am late for my appointment. It is my responsibility to arrive on time.
- I agree to keep my account balance current by paying at each visit.
- Unpaid fees over 90 days will be sent to collections or filed in court, unless prior arrangements have been made and past due accounts are kept current.

SIGNATURE OF PATIENT OR LEGAL GUARDIAN ____________________ DATE __________

ROCHESTER REGIONAL HEALTH
Clifton Springs Hospital & Clinic

Patient Name ________________________________ **DOB**_____________

PRIMARY INSURANCE INFORMATION – ACUPUNCTURE PATIENTS ONLY

____ ________________________
NAME OF SUBSCRIBER SUBSCRIBER'S DATE OF BIRTH

________________________________ ( )_________________
RELATIONSHIP TO PATIENT SUBSCRIBER PHONE NUMBER

____ ____________________________________
NAME OF INSURANCE CARRIER/PLAN SUBSCRIBER ID# (INCLUDE ALL LETTERS & NUMBERS)

□ *I UNDERSTAND THAT INSURANCE COVERAGE FOR ACUPUNCTURE IS LIMITED & I HAVE CONTACTED MY INSURANCE COMPANY TO VERIFY COVERAGE AND POLICIES UNDER MY PLAN.*

FOR OFFICE USE ONLY:
INSURANCE VERIFICATION DATE _____________ DEDUCTIBLE? □Y □N DEDUCTIBLE AMT REMAINING$_______ AS OF __________(DATE)

COVERAGE COPAY/COINSURANCE ____________ APPROVED # VISITS: _____ OTHER ____

☐ RELEASE OF INFORMATION FOR PAYMENT & ASSIGNMENT OF BENEFITS

I AUTHORIZE AND DIRECT THE CLIFTON SPRINGS HOSPITAL AND CLINIC AND PHYSICIAN PROVIDERS HAVING TREATED ME, TO RELEASE TO GOVERNMENTAL AGENCIES, INSURANCE CARRIERS, AND OTHERS WHO ARE FINANCIALLY LIABLE FOR MY HOSPITALIZATION AND MEDICAL CARE, ALL INFORMATION NEEDED TO SUBSTANTIATE PAYMENT AND TO PERMIT REPRESENTATIVES THEREOF TO EXAMINE AND MAKE COPIES OF ALL RECORDS RELATING TO SUCH CARE AND TREATMENT.
I HEREBY AUTHORIZE AND TRANSFER OVER TO THE CLIFTON SPRINGS HOSPITAL AND CLINIC AND PHYSICIAN PROVIDERS SUFFICIENT MONIES AND/OR BENEFITS TO WHICH I MAY BE ENTITLED FROM GOVERNMENTAL AGENCIES, INSURANCE CARRIERS, OR OTHERS WHO ARE FINANCIALLY LIABLE FOR MY HOSPITALIZATION AND MEDICAL CARE TO COVER THE COSTS OF THE CARE AND TREATMENT RENDERED TO MYSELF OR MY DEPENDENT IN SAID HOSPITAL.

☐ COORDINATION OF BENEFITS

I AGREE TO PROVIDE INFORMATION TO THE CLIFTON SPRINGS HOSPITAL AND CLINIC AND PHYSICIAN PROVIDERS FOR ALL GROUP HOSPITALIZATION, WORKER'S COMPENSATION OR OTHER HOSPITAL BENEFITS TO WHICH I MAY BE ENTITLED. I AUTHORIZE THE HOSPITAL TO BILL FOR SERVICES GIVEN TO ME ACCORDING TO THE CO-INSURANCE TERMS OF THESE CONTRACTS.
I UNDERSTAND THAT I MUST PROVIDE ALL NECESSARY BILLING INFORMATION TO THE CLIFTON SPRINGS HOSPITAL AND CLINIC WITHIN 30 DAYS OF THE DATE OF SERVICE. I UNDERSTAND THAT IF I DO NOT PROVIDE THE CLIFTON SPRINGS HOSPITAL AND CLINIC THE NECESSARY INFORMATION AND MY CLAIM IS NOT RECEIVED BY THE CARRIER ON OR BEFORE THE 45TH DAY, I WILL BE RESPONSIBLE FOR THE BILL.

PATIENT/GUARANTOR SIGNATURE____DATE:__________
(IF MINOR, PARENT/GUARDIAN SIGNATURE – **MUST** INCLUDE RELATIONSHIP TO PATIENT)

ROCHESTER REGIONAL HEALTH
Clifton Springs Hospital & Clinic

Patient Name ______________________________ **DOB**____________

The Springs Integrative Medicine Center and Spa - Health History Intake Form

TODAY'S DATE ____________________

WHO IS YOUR PRIMARY CARE DOCTOR? ____

NAMES OF MEDICAL SPECIALISTS WHO TREAT YOU & WHY DO YOU SEE HIM OR HER?

____

____

____

WHAT IS THE PRIMARY REASON YOU ARE SEEKING TREATMENT AT THE SPRINGS? ____

DO YOU HAVE ANY PAIN? - *please include recent pain history even if you are not in pain today.* ☐YES ☐NO

DESCRIBE YOUR PAIN: ____

____

____

DO YOU HAVE TROUBLE MOVING ANY JOINTS? ☐YES ☐NO

WHAT JOINTS OR MOVEMENTS ARE RESTRICTED? ____

____

WHAT ARE YOUR MAJOR SOURCES OF STRESS?

1 ____________ 2 ____________ 3 ____________

4 ____________ 5 ____________ 6 ____________

DO YOU HAVE A BLEEDING DISORDER? ☐YES ☐NO

DO YOU TAKE/USE ANY OF THE FOLLOWING MEDICATIONS?

PRESCRIPTION BLOOD THINNERS (EX. COUMADIN, WARFARIN, HEPARIN)?	☐YES	☐NO
STATIN DRUGS FOR CHOLESTEROL?	☐YES	☐NO
ARE YOU TAKING ANY MEDICATIONS THAT ALTER YOUR MENTAL STATUS?	☐YES	☐NO
DO YOU TAKE OPIOIDS FOR PAIN?	☐YES	☐NO

ALLERGIES

DRUGS/MEDICATIONS	☐YES	☐NO	SPECIFY:
GLUTEN	☐YES	☐NO	SPECIFY:
IODINE/SEAFOOD	☐YES	☐NO	SPECIFY:
OTHER FOODS	☐YES	☐NO	SPECIFY:
PLANTS/ENVIRONMENTAL	☐YES	☐NO	SPECIFY:
OTHER	☐YES	☐NO	SPECIFY:
SKIN SENSITIVITIES/REACTIONS TO PRODUCTS/INGREDIENTS	☐YES	☐NO	SPECIFY:

MAIN MEDICAL HISTORY (PLEASE INCLUDE DATES):

MEDICAL DIAGNOSES:

SURGERIES OR INJURIES:

ROCHESTER REGIONAL HEALTH
Clifton Springs Hospital & Clinic

Patient Name ________________________________ **DOB**_____________

The Springs Integrative Medicine Center and Spa - Health History Intake Form

PLEASE LIST PRESCRIPTION & OVER THE COUNTER MEDICATIONS:	PLEASE LIST HERBS, SUPPLEMENTS, VITAMINS, ETC:

DO YOU HAVE NOW, OR IN THE PAST ANY OF THE FOLLOWING:

CONDITION/SYMPTOM	NOW	PAST
DIABETES	☐	☐
MEMORY LOSS	☐	☐
LIGHT HEADED/DIZZY/VERTIGO	☐	☐
FAINTING/LOSS OF BALANCE	☐	☐
FALLS	☐	☐
BLOOD CLOTS OR PHLEBITIS	☐	☐
HEART DISEASE	☐	☐
HIGH BLOOD PRESSURE	☐	☐
LOW BLOOD PRESSURE	☐	☐
HAVE YOU HAD A STROKE?	☐	☐
SWELLING/EDEMA	☐	☐
OSTEOPOROSIS/OSTEOPENIA	☐	☐

CONDITION/SYMPTOM	NOW	PAST
CANCER	☐	☐
TYPE: ________________________________		
WHEN: ________________________________		
TREATMENT: ____________________________		
LYMPH NODES REMOVED?	☐	☐
HOW MANY? _____________________________		
WHICH NODES? __________________________		

PLEASE LIST ANY OTHER MEDICAL CONDITIONS, SYMPTOMS, OR SITUATIONS THE PRACTITIONER SHOULD BE AWARE OF PRIOR TO YOUR TREATMENT:

____

____

____

____

____

THE INFORMATION I HAVE PROVIDED IS TRUE AND COMPLETE TO THE BEST OF MY KNOWLEDGE. I AGREE TO INFORM MY PRACTITIONER OF ANY CHANGES IN MY HEALTH PRIOR TO TREATMENT.

____ ________________

PATIENT SIGNATURE DATE