

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 _____

() _____ () _____ () _____ EXT: _____
HOME PHONE CELL PHONE WORK PHONE

CHECK BOX IF YOU WOULD LIKE TEXT MESSAGE REMINDERS FOR APPOINTMENTS – PLEASE NOTE: YOU MUST CALL TO CANCEL OR RESCHEDULE. THE AUTOMATED SYSTEM CANNOT ACCEPT CANCELLATIONS.

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

Patient Name _____ DOB _____

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

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)

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: _____

