Healing Hands Wellness Center

New Patient Form

Patient Information

Full Name (First, Middle Initial & Last) _____

Date of Birth _____ Social Security # _____ Male or Female (check one)

Street Address _____

City _____ State _____ Zip _____ Email _____

Home Phone _____ Work Phone _____ Cell Phone _____

Marital Status S M D W Spouse's name _____ Ref by _____

Insured Information If you are the insured mark this box and skip to Insurance Information section

Full Name (First, Middle Initial & Last) _____

Relationship to patient _____ Date of Birth _____ SS # _____

Street Address _____

City _____ State _____ Zip _____ Email _____

Home Phone _____ Alternate Phone _____

Insurance Information If you have a secondary insurance, please list the same information as below on the back of this form.

Insurance Carrier _____

Policy Number _____ Group Number _____

Street Address _____

City _____ State _____ Zip _____ Phone _____

Employer Information

Current Employer _____ Position _____

Are you, or do you think you may be pregnant? YES NO Cause of Current Complaint: Auto Accident Work Injury Other

Do you currently have an auto accident or worker's compensation case pending? YES NO

I understand and agree that health and accident insurance policies are an arrangement between the insurance carrier and myself. I authorize payment from my insurance carrier directly to this office with the understanding that all monies be credited to my account upon receipt. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER MY INSURANCE POLICY. I also authorize the release of any information pertinent to my case to any insurance company, adjuster, or attorney for the purpose of securing payment under this policy of insurance. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I understand that if I suspend or terminate my cure and treatment, all fees for professional services rendered me will be immediately due and payable. In the event of my default, I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney fees as may be required to effect collection.

Patient's Signature _____ Date _____

Financial Responsibility/Waiver

We can bill your health insurance company as a convenience to you. You are responsible for knowing about your insurance coverage prior to your appointment. You are responsible for obtaining any necessary authorizations prior to your appointment. You will be responsible for your entire bill if you do not have the required authorization. If your visits are not covered by your insurance plan, you will be responsible for the entire bill. Co-payments and/or deductibles are due at the time of your visit.

I have read and understand my financial responsibility to Healing Hands Wellness Center and hereby affix my signature as an acknowledgement of this understanding.

Responsible Party's Signature _____ Date _____

Name of Responsible Party _____ Witness _____