OCCUPATION _____

EMPLOYER_____

PRIMARY MD_____ PHONE:

_____

REFERRING MD_____ PHONE:

_____

PHARMACY _____ PHONE:

_____

PERSONAL RESPONISIBLITY FOR PAYMENT

NAME _____ RELATIONSHIP TO

PATIENT_____

ADDRESS _____CITY _____ ZIP

_____

SS# _____ BIRTHDAY _____ SEX F

M

EMPLOYER _____ DMV LIC

#_____

EMERGENCY CONTACT

NAME: _____ RELATIONSHIP:_____ PHONE:

_____

INSURANCE INFORMATION

PRIMARY INSURANCE: _____ PHONE:

_____

SUBSCRIBER NAME: _____RELATIONSHIP TO PATIENT

_____

SUBSCRIBER SS# _____BIRTHDAY_____ SEX

_____

SUBSCRIBER ID # _____ GROUP # _____ PLAN #

_____

SECONDARY INSURANCE:_____ PHONE:

_____

SUBSCRIBER NAME _____ RELATIONSHIP TO PATIENT

_____

SUBSCRIBER SS# _____BIRTHDAY_____ SEX

_____

CERTIFICATE # _____ GROUP # _____ PLAN #

_____

ASSIGNMENT & RELEASE: I HEREBY ASSIGN MY INSURANCE TO BE PAID DIRECTLY TO THE UNDERSIGNED PHYSICAN. I AM FINANCIALLY RESPONSIBLE FOR NONCOVERED SERVICES, I ALSO AUTHORIZE THE UNDERSIGNED PHYSICAN TO RELEASE TO MY INSURANCE CARRIERS ANY INFORMATION REQUIRED TO PROCESS THIS CLAIM. FURTHERMORE, I AGREE TO ALL OFFICE POLICIES AND PROCEDURES.

At Wellspring Health we value your time. This is why we <u>do not</u> overbook our schedule unless there is a physician will use his or her discretion as to whether to allow you to return. This policy is to help us maintain medical emergency. The time we have scheduled for your appointment is never used to schedule additional our commitment to those patients who are truly seeking a partnership for perfect health.
patients. There is rarely a long wait in our office because of this policy. We honor our time with our patients

SIGNATURE_____

DATE

and we want our patients to value our commitment to them. If you miss two scheduled clinic appointments within 48 hours of your visit without notification, you will be eligible to be discharged from our clinic. To be considered for reinstatement into the clinic, you will be charged $75 per missed appointment and your