Los Gatos
408.884.1972
14127 Capri Drive, Suite 5A , CA 95032

WHOLE
medicine

Client Registration Form

Name

First: ______________ Middle: ______________

Last: ______________

Date of Birth: ______________

Gender: ◯ Male ◯ Female

Phones

Home: ______________

Mobile: ______________

Work: ______________

Preferred: ◯ Home ◯ Mobile ◯ Work

Address

Line 1: ______________

Line 2: ______________

City: ______________

State: ______________ Zipcode: ______________

Email

Email address: ______________

Receive Practitioner's Newsletter: ◯ Yes ◯ No

Here to See

Practitioner: ______________

Appointment Reminders

by: ◯ Phone ◯ SMS ◯ Email

Emergency Contact

Name: ______________

Email: ______________

Phone: ______________

Relationship: ______________

Insurance Information

Subscriber Name: ______________

Subscriber Date of Birth: ______________

Subscriber ID: ______________

Relation to Client: ◯ Self ◯ Spouse ◯ Parent ◯ Other

Insurance Co. Name: ______________

Insurance Co. Provider Phone: ______________

How Did You Hear About Us?

◯ Online: ______________

◯ Referred by: ______________

◯ Other: ______________

Office Administrative Policies

Cancellation

This office requires 24hrs notice for cancellation. Please understand that the practitioner dedicates a significant amount of time for each client visit, and this time lost represents a person who could have received treatment. You may request, at the time of scheduling your appointment, an automated reminder service which will contact you 48 hours before your scheduled appointment. Except in the case of physical emergency, appointments missed without sufficient notice will be billed at $50.00 and cannot be claimed to insurance. **Your signature below indicates your acceptance of this policy.**

Payment

Whole Medicine is a fee-for-service provider. Payment is due in full at the time of treatment. If treatment is terminated, all fees for services rendered will be immediately due and payable.

Insurance

As a courtesy, Whole Medicine provides direct billing service to most health insurance companies. Be aware that benefits quoted by insurance are subject to change upon receipt of claim. Please note that your insurance policy is an agreement between you and your insurance company, and that you are personally responsible for all of the charges to your account should your insurance company refuse payment for services rendered. All deductibles, co-payments and 'patient portions' are due at time of service.

Please be aware that Whole Medicine may not be on your panel of contracted primary care providers, so you may not receive full or typical reimbursement for received services. Whole Medicine is not a Medicare provider; no claims will be submitted by this office on your behalf to Medicare, and Medicare will not reimburse you for services rendered.

I have read and agree to the office administrative policies.

Client Name: ______________________ Client Signature: ____________________________ Date: ________________

Consent to the Use and Disclosure of Health Information for Treatment & Payment

I understand that as part of my healthcare, my practitioner originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care. I understand that this information serves as:

- A basis for planning my care and treatment.
- A means of communication among health professionals who contribute to my care.
- A source of information for applying my diagnosis and treatment to my bill.
- A means by which a third-party payer can verify that services billed were actually provided.

I understand and have been provided with a Notice of Information Practices (http://wholemedicine.net/hippa) that provides a more complete description of information uses and disclosures.

I understand that I have the right to review the notice prior to signing this consent.

I understand that the organization reserves the right to change their notice and practices and prior to implementation will mail a copy of any revised notice to the address I've provided.

I understand that I have the right to object to the use of my health information for directory purposes.

I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that the organization is not required to agree to the restrictions requested.

I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon.

I request the following restrictions to the use or disclosure of my health information:

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I have read and consent to the use and disclosure of health information for treatment and payment.

Client Name: ______________________ Client Signature: ____________________________ Date: ________________