

Integrative Health Specialists of Indiana

(317) 580-9333-phone/ (317) 818-8933-fax

Patient Registration Form

Patient Name (first, middle, last) _____		
Patient Address _____		
City _____	State _____	Zip _____
Telephone(s) Home () _____	Work () _____	Cell () _____
Date of Birth _____	SSN# _____	Marital Status _____
Email _____	Medication Allergy _____	Referred by _____

Employer _____ Status: Full-time Part-time Retired None
Employer Address _____ City/State/Zip _____

Emergency Contact List <u>one</u> person we have permission to contact
Name _____ Relationship _____ Phone() _____
Address _____ City/State/Zip _____

Insurance Co. _____ Policy/ID _____ Member: Self or Spouse
Insurance Co. (Secondary) _____ Policy/ID _____ Member: Self or Spouse

Policyholder Information
Name _____ Date of Birth _____
Address _____ City/State/Zip _____
SSN# _____ Home Telephone () _____
Relationship to Patient _____ Work Telephone () _____

Family Doctor _____ Phone Number() _____

AUTHORIZATION TO PAY BENEFITS TO PROVIDER AND TO RELEASE INFORMATION

I request payment of benefits to be made to Integrative Health Specialists (IHS) for any services furnished to me by this group. I authorize any holder of medical information about me to release to the insurance carrier(s) and its agents any information needed to determine these benefits or the benefits payable for related services. I recognize that if my insurance carrier(s) requires a referral and/or authorization for any or all services rendered by IHS that I am responsible for obtaining the referral and /or authorization. In the absence of such referral and/or authorization, I will be held financially liable for the full amount of the charges for services rendered. I am also responsible for out of network charges. In consideration of services rendered, the undersigned shall be personally obligated to pay for any services not covered by health insurance or any other source of reimbursement. I agree to pay IHS for any amounts not paid by my insurance carrier for medical services rendered. I am also responsible for any attorney fees required to collect for these services, court costs and collection agency fees.

NO-SHOW POLICY

There will be a \$25 fee for not canceling appointments at least 24 hours prior to scheduled time.

_____ **Initial Here for Authorization to Pay and No-Show Policy**

_____ Today's Date _____

Patient/Responsible Party

Payment is expected at the time of service – Thank You

revised 6/12