Integrative Health Specialists of Indiana

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

Patient Registration Form

Account Number: _____

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_____

Pharmacy Name: _____ Phone #: _____

Employer _____ Status: ❑Full-time ❑Part-time ❑Retired ❑None

Employer Address _____City/State/Zip _____

Emergency Contact List **one** person we have permission to contact

Name _____Relationship _____ Phone( ) _____

Address _____City/State/Zip _____

Policyholder Information **Self Pay** _____

Name/Self_____ Date of Birth _____

Address/Same as above _____City/State/Zip _____

SSN# _____ Home Telephone ( ) _____

Relationship to Patient _____Work Telephone ( ) _____

Primary Care Doctor _____ Phone Number( )_____

****WE ARE NOT PRIMARY CARE _____Initial here**

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

revised 02/22

Payment is expected at the time of service-Thank You