whole family wellness

Elisa Song, MD | Donna Ruiz, MD | Suruchi Chandra, MD | Christina Peretz, MD | Kandice Stellmon, NC

# Adult New Patient Registration Form

**Requesting Appointment With:** **Date:** _____

☐ Dr. Elisa Song (not available)
☐ **Dr. Donna Ruiz**
☐ **Kandice Stellmon, NC**
☐ **Dr. Suruchi Chandra**
☐ **Dr. Christina Peretz**

**Patient's Name:** _____ **DOB:** _____ **Male** ◯ **Female** ◯

**Home Address:** _____ **City:** _____ **State:** ____ **Zip:** _____

***(For parents, use sections below)***

**Home Telephone #:** _____ **Mobile #:** _____ **Work #:** _____

**E-mail:** _____

**Employer:** _____ **Occupation:** _____

**Insurance Company:** _____

**Claim Mailing Address:** _____

**Insured Name:** _____ **Relation to Patient:** _____

**Insurance ID #:** _____ **Group #:** _____

**Who may we thank for your referral?** _____

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**Patient's Name:** _____

**Authorization for Integrative Medical Treatment**

I authorize the practitioners at Whole Family Wellness to administer such medical and health care services, treatments and procedures for me as they deem appropriate and necessary.

I understand that my practitioner will prescribe an integrative treatment program for me which may include conventional medical care, nutritional therapies, acupuncture, homeopathy, herbal medicine, traditional Chinese medicine, functional medicine, biomedical approaches to autism, and other aspects of integrative medical treatment. As a patient seeking integrative medical treatment, I understand that I must decide, in conjunction with my practitioner, what course of treatment will best benefit me. I understand that any or all of the above referenced treatment modalities may be considered unproven or experimental by other doctors, medical agencies, or third party payers and may not be reimbursable.

I understand that the benefits and/or risks and dangers of any treatment program prescribed by my practitioner will be explained to me to my full satisfaction. I understand that if any explanations as to the benefits and/or the risks and dangers of any of the prescribed treatment programs are unclear, it is my responsibility to ask for clarification before giving my consent to treatment. While I understand that there have been no warranties or assurances of successful outcome for myself, I nevertheless desire to pursue integrative medical treatment for myself after having considered all factors, including the information contained herein.

I understand that it is my responsibility to contact Whole Family Wellness to report any issues that I am having with the treatment program, and to schedule consult time to make program adjustments and to conduct appropriate testing. I am responsible for seeking professional medical attention from my practitioner at Whole Family Wellness or another facility if I experience any unanticipated or unpleasant effects associated with treatment or a worsening my condition. If an emergency medical condition arises, I will seek treatment for myself immediately from the nearest emergency department or by calling 9-1-1.

_____ **Initial**

**Please initial here and sign the last page to indicate you have read and accept the terms of this section.**

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**Patient's Name:** _____

**Authorization for Payment**

I hereby authorize Whole Family Wellness to charge my account balance to the credit card indicated below. I authorize this credit card to be used as a guarantee against late cancellations and missed appointments, and for any and all balances including those relating to office visits, telephone/e-mail consultations, missed/late appointments, miscellaneous fees, and charges for nutritional supplements. I agree that if my credit card does not accept the charge, I will immediately make payment to Whole Family Wellness, Inc. for the amount due. I understand that I may cancel this authorization in writing at any time.

**Visa/MC (circle type) #:** _____ **Exp Date**: _____ **Security Code:** _____

**Authorized signature:** _____

**Cancellation Policy**

I understand that I am expected to keep all my appointments as scheduled in order to ensure maximum progress in my treatment. I understand that the practitioner's time is reserved exclusively for my care for the duration of all scheduled visits, and that if I am late for my visit, the visit will end at the scheduled time and I will still be charged for the full visit time. If for some reason I cannot make an appointment, I will call at least **2 business days in advance** to cancel or reschedule that visit. I understand that if I cancel an appointment **less than 2 business days** prior to the scheduled time, I will be charged a fee that represents 50% of the cost of my scheduled appointment. I further understand that if I cancel **less than 1 business day** before my appointment, or fail to show for my appointment, I will be charged a fee that represents the full cost of my scheduled appointment.

_____ **Initial**

**Please initial here and sign the last page to indicate you have read and accept the terms of this section.**

**Telephone/E-mail Policy**

I understand that for non-urgent calls that occur after hours or on weekends, or telephone calls over 10 minutes that occur at any time, will be billed at the same consultation rate as in-person visits and charged to my credit card on file.

I further understand that e-mails which take over 10 minutes to read and reply will be billed at the in-person consultation rate and charged to my credit card on file. By sending an e-mail, I acknowledge and agree that a prompt reply is NOT required, expected, or contemplated. I acknowledge that I will not use e-mail communication to deal with emergencies or other time-sensitive issues. I understand that e-mail communications may not be secure and that there is some possibility that confidentiality of such communications may be breached by a third party. I understand that Whole Family Wellness may keep copies of e-mail communications and that such messages may be included in your, or your child's, medical record.

_____ **Initial**

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**Patient's Name:** _____

**Receipt of Whole Family Wellness Policies and Notice of Privacy Practices**

I hereby acknowledge that I have read and agree to the terms stated in the Whole Family Wellness document titled **Whole Family Wellness Policies**.

I claim full financial responsibility for all services rendered at Whole Family Wellness. I understand that payment is required in full at the time of service. I understand that fees may change without notice.

I understand Whole Family Wellness is not contracted with any insurance plans, and that my, or my insurance plan may not reimburse for services rendered at Whole Family Wellness, including office visits and telephone/e-mail consultations. I also understand that some of the lab tests that are ordered, particularly those that are used in support of integrative consultations, or that are kits sent to labs using innovative approaches to diagnostics, may also not be reimbursed.

I understand that it is my responsibility to know my insurance plan benefits. I understand that Whole Family Wellness will file an insurance claim on my behalf as a courtesy, but that all pre-authorizations for visits and follow-up for insurance claims is my responsibility.

I hereby acknowledge that I have read and agree to the terms stated in the Whole Family Wellness document titled **Notice of Privacy Practices** and consent to the use and collection of personal and medical information described herein.

_____ **Initial**

**Please initial here and sign the last page to indicate you have read and accept the terms of this section.**

**Authorization to Release Information to Insurance Carrier**

I authorize Whole Family Wellness to submit to my insurance carrier any information acquired in the course of my examination or treatment which may be required to process my claim for payment.

_____ **Initial**

**Please initial here and sign the last page to indicate you have read and accept the terms of this section.**

_____

**Responsible Party's Signature**

**Date:** _____

**Relation to Patient:** _____