Francis Holistic Medical Center, P.C.
Patient Registration

Please: Read carefully, print legibly, and fill in ALL spaces. Today's Date:

Patient's Name: ____________________ Date of Birth: ____________________
Address: ____________________ Home Phone: (____) ______________
City: ______________ State: _______ Zip: _______ Work Phone: (____) ______________
SS#: ______________ Age: _______ Sex: ______ Cell Phone: (____) ______________

Primary Care Physician: ____________________ Phone: (____) ______________
Address: ____
City: ______________________________ State: ___________ Zip: __________

Whom may we thank for referring you? ________________________________
Phone # if Physician: (____) ______________________

Holder of Insurance: ____________________ Relationship to Patient: _____________
Place of Employment: ____________________ Occupation: ______________________
Address: ____________________ Work Phone: (____) ______________
City: ______________________ State: _________ Zip: _________ SS#: ______________

The responsible party may be the adult patient, parent, spouse, grandparent, legal guardian or insurance policy holder.

Responsible Party: ____________________ Relationship to Patient: _____________
Place of Employment: ____________________ Occupation: ______________________
Address: ____________________ Home Phone: (____) ______________
City: ______________________ State: _________ Zip: _________ SS#: ______________

Primary Insurance	Secondary Insurance
Insurance Co: ____________________	Insurance Co: ____________________
____________________	____________________
Phone: (____) ____________________	Phone: (____) ____________________
Insured's Name: ____________________	Insured's Name: ____________________
Policy #: ____________________	Policy #: ____________________
Group #: ____________________	Group #: ____________________
Deductible: $_______ ( ) Yearly ( ) Quarterly	Deductible: $_______ ( ) Yearly ( ) Quarterly
( ) HMO ( ) PPO ( ) Co-pay amount: $ ____	( ) HMO ( ) PPO ( ) Co-pay amount: $ ____

Acknowledgement and Authority

By my signature below, I consent to treatment as necessary or desirable to the patient named above, including but not restricted to whatever drugs, medicines, laboratory, X-ray or other studies that may be used by the attending physician, nurse, or qualified designates. I also acknowledge full responsibility for the payment of such services and agree to pay for them in full at the time of service unless other arrangements are made. I understand that I am financially responsible even if this office has agreed to bill my insurance.

Should I find myself under the care of an on-call, covering practitioner, I agree to hold him/her not legally medically liable should I choose to engage in holistic or alternative medical practices and treatments with which the practitioner is not familiar or to which he/she does not subscribe.

Moreover, if I choose to undertake holistic or alternative treatments with which the practitioners at Francis Holistic Medical Center are not familiar, or to which they do not subscribe, I will hold them harmless for any ensuing adverse events. Please initial: _________

Responsible Party Signature: ______________________________ Date: ________________

Patient's Name: ____ Date of Birth: __________________

Dear Patient: In an effort to keep your focus and ours on the care of your health and to assure that your office visits are free of misunderstandings, we would like to present our financial policies:

FINANCIAL RESPONSIBILITY – I understand that I and/or my family are ultimately responsible for all services rendered by the office of the Francis Holistic Medical Center, PC. I further understand that I am financially responsible for payment of all deductibles as well as any copays and/or coinsurance not covered by my or my dependent's insurance carrier. I agree to pay promptly and directly to the Francis Holistic Medical Center any deductibles, copays and coinsurances, as well as any unpaid balances not covered by insurance policy/policies for services rendered to me or my dependent. Copay payment will be paid upon arrival to each treatment. The office will bill insurances once I have established that they will cover my services. I will notify you immediately of any changes in my insurance, address or phone number. I will make payment on all unpaid balances within 15 days or by my next visit, whichever comes first. I understand that there is a $30.00 fee for a returned check and that payment in full for **uncovered** services is due at the time of my visit.

ASSIGNMENT OF BENEFITS – I hereby assign and authorize payment of all medical benefits directly to the Francis Holistic Medical Center, PC to include major medical benefits to which I (or my dependent) am entitled, including Medicare and other government-sponsored programs, private insurance and any other health plans for all charges incurred by me or my dependent. I understand that I am ultimately financially responsible for all charges whether or not they are paid by my insurance. I hereby authorize the Francis Holistic Medical Center to release any and all information necessary to secure the payment of said benefits but will not require the office to submit treatment plans to receive payment from my insurance company. In the event my insurance carrier refuses to pay without a treatment plan, then that bill will become immediately payable by myself.

RELEASE OF INFORMATION – I hereby authorize the Francis Holistic Medical Center, PC to disclose or obtain all or any part of my or my dependent's record to or from any person or corporation which may be liable for all or part of the charges of the Francis Holistic Medical Center, PC, including but not limited to, insurance companies, doctors, legal counsel, worker's compensation carriers or employers.

CANCELLATION AND NO-SHOW POLICY –
New Patients – $40.00 retainer in advance; plus ½-fee charge for cancellations with less-than-24 hours notice (business day).
Doctor Visits – ½-fee charge for cancellations with less-than-24 hours notice (business day).
IV Appointments – $40 fee for cancellations with less-than-24 hours notice (business day). If the IV has been mixed, there is an additional $25 fee.
Allergy Testing – $25 fee for cancellation of ½-day testing with less-than-24 hours notice (business day). There is a $50 fee if full-day testing is cancelled with less-than-24 hours notice (business day).

TREATMENT RENDERED WITHOUT PROPER INSURANCE REFERRALS/AUTHORIZATION – I understand that if I am a member of a private health insurance carrier that requires referrals and/or authorization for the Francis Holistic Medical Center, PC, then for each treatment for which I do not have a referral or an authorization to be seen, I will be responsible for payment of services rendered should these treatments be denied by my health insurance carrier.

I HAVE READ AND UNDERSTAND THE ABOVE. I CONSENT TO BE EVALUATED AND TREATED BY THE FRANCIS HOLISTIC MEDICAL CENTER, PC.

SIGNATURE: ____ **DATE**: _________________________
PATIENT (or PARENT if patient is a minor)

We welcome the opportunity to discuss your account with you. If this is not satisfying, you may discuss it with the practitioner at the beginning of your next consultative visit.

We extend our appreciation to you for taking the responsibility to be faithful to your financial arrangements with this office. Thank you, from your FHMC staff!