INTEGRATIVE HEALTH SOLUTIONS

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REGISTRATION INFORMATION

Date: _____/_____/_____; Phone #'s: (_____)_____-_____ (_____)_____-_____

Patient Name: _____
First Name Middle Initial Last Name

Home Address: _____

_____
City State Zip

Social Sec. #: _____-_____-_____; Date of Birth: ___/___/___; Age: ____; Sex: M F

Emergency Contact
Name and Phone Number:_____(____)_____

Responsible Party/Parent's Names (if minor):_____

Email Address_____ Referred By_____

POLICY

You are financially responsible for payment of all services at the time of visit. A minimum of 24 hours advance notice of cancellation of all appointments is required, otherwise you may be charged for all or part of the missed appointment. Dr. Handwerger does not participate in Medicare or any insurance plans. Dr. Handwerger ND accepts no assignment and processes no medical insurance. Patients are given an original receipt, which can be submitted by the patient to their carrier(s), but we accept no responsibility whatsoever for the extent of reimbursement by that carrier(s). The carrier(s) may then reimburse the patient directly, in whole, in part, or not at all, according to the carrier(s) provisions. In order to facilitate the payment process, we accept major credit cards. You have the right to privacy to the fullest extent. Except in the case of extenuating circumstance, personal patient information will be kept confidential. We will not electronically transmit personal patient information, nor are we a healthcare clearinghouse or health plan. You assume the risks connected with participation in any and all modalities and services offered by Dr. Handwerger. Beyond the reason you are requesting care, you represent that you are otherwise in good health and suffer from no physical impairment which would limit the use of the modalities, facilities and/or services you are requesting from us. Furthermore, you agree that Dr. Bronner Handwerger ND, Integrative Health Solutions, its practitioners, officers, employees and agents shall not be liable for any claim, demand, or cause of action of any kind whatsoever for, or on account of death, personal injury, property damage or loss of any kind resulting from or related to his/her use of the modalities, facilities and/or services from Dr. Bronner Handwerger ND APC or Integrative Health Solutions. Finally, you are authorizing us to obtain any relevant medical and health information from other practitioners and/or hospitals necessary for your proper treatment and care. Your signature below indicates that you understand, agree, and accept the terms indicated.

Your Signature: _____ Date: ____/____/____