Restorative Health Clinic

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Welcome Form

Thank you for selecting our healthcare team! We will strive to provide you with the best possible healthcare. To help us meet all your healthcare needs, please fill out this form completely in ink. If you have any questions or need assistance, please ask us-we will be happy to help.

Personal Information

Date_____Birth Date_____
SS#/SIN_____
Name_____Wished to be called_____
Male Female Minor Single Married Divorced Widowed Separated
Address_____
City_____State_____Zip_____
Employer_____Occupation_____
Referred by_____How did you hear about us?_____

Contact Information

Home Phone_____ Pharmacy Phone#_
Work Phone_____Ext#_____
Cell Phone_____E-mail_____
Where do you prefer to receive calls? Home Cell Phone
When is the best time to reach you? Time Days

_____**(your initials)** I give permission for the staff at Restorative Health Clinic to contact me via telephone and leave a message that may contain appointment or medical information if I am not available.

In the event of an emergency, who should we contact?
Name_____Relationship_____
Work#_____Home#_____Cell Phone#_____

Insurance Information

Primary Insurance

Name of Insured_____Relationship to Patient_____
Insured's birth date_____SS#/SIN_____
Employer_____Date Employed_____
Occupation_____
Insurance Company_____Group#_____
ID#_____ Insurance Address_____
Deductible_____Amount already used_____
Max. annual benefit_____

Secondary Insurance (If available) **Welcome Form Page 2**

Name of Insured_____ Relationship to patient _____
Insured's birth date _____ SS#/SIN _____
Insurance Company_____Group#_____
ID# _____ Insurance Address _____
Deductible _____Amount already used
Max. annual benefit_____

Responsible Party

Who is responsible for the account? Name_____
Relationship to patient_____Birth date_____
Address_____
City_____State_____Zip_____
Email_____Home Phone_____Cell_____

Authorization and Release

_____**(Initials)** I authorize the release of any information under the HIPA Act, including the diagnosis and the records of any treatment or examination rendered to me or my child during the period of such care to third party payors and/ or other health care practitioners.

_____**(Initials)** I authorize and request my insurance company to pay directly to the doctor or doctor's group insurance benefits otherwise payable to me.

_____**(Initials)** I understand that the payment for all the services not covered by insurance or/and for the medicinary items is due at the time of the visit. We accept cash, checks, Visa/Amex/Discover/MC. Returned checks will be subject to a $35.00 NSF fee.

_____**(Initials**) I understand that my insurance carrier may pay less than the actual bill for service. Once the insurance has determined their coverage for the services I received, I agree to be responsible for the balance according to my insurance allowed fees.

_____**Signature** of patient or parent/ guardian if minor

Consent for Treatment

I consent to receive medical care by the licensed health care professionals at Restorative Health Clinic. I understand that all the services rendered are services permitted under the Oregon Naturopathic Doctor License, which may include but are not limited to botanical medicine, hydrotherapy, homeopathy, nutritional supplements and counseling, injections, IV therapy, and prescription drugs included in the OR naturopathic formulary.

_____**Signature** of patient or parent/guardian if minor

_____**Date**