INTEGRATIVE FAMILY MEDICINE
WHOLE HEALTH FOR THE WHOLE FAMILY

Patient Registration Form

Patient Name:_____ SEX: M / F

Date of Birth:_____ Social Security #:_____-_____-_____ DL#_____

E-mail address:_____

Home Phone: _____Work:_____Cell:_____

Street Address:_____

City:_____ State:_____ Zip Code:_____

Preferred Pharmacy/Location:_____

Employer _____ Phone _____

Employer Address _____

If Student, School Name _____ Full-Time / Part-Time

Responsible Party *(If you are a dependent only)*

Name:_____ Phone_____

Date of Birth:_____ Social Security #: _____-_____-_____ DL#_____

E-mail address:_____

Street Address:_____

City_____ State:_____ Zip Code:_____

We prefer to use e-mail when sending appointment reminders and will notify you by phone for lab results. If e-mail is NOT the most effective way to contact you please indicate your preference of contact method:

Referred By:_____

Emergency Contact Name:_____ Relationship:_____

Emergency Contact Phone:_____

With whom may we discuss test results or therapies? *(Please provide at least one contact)*

Name:_____ Relationship:_____ phone:_____

Name:_____ Relationship:_____ phone:_____

(PLEASE INITIAL CONSENT ON BACK PAGE)

Continued:

Patient Consent Form

Patient Name:_____ Date of Birth:_____

Do you have Medicare insurance ☐ Yes ☐ No *Medicare insurance will only be seen by private contract.*

Do you have a living will? ☐ Yes ☐ No

Do you have a durable power of attorney for health care? Yes ☐ No ☐

Office Policies and Procedures Agreement: *By initialing here you are stating you have received and agree with terms in the IFM Policies and Procedures Guide. A written copy will be provided to you at your request.* _____

Patient Consent for Treatment: *You are consenting to treatment by a physician/and or medical staff in this office. "Treatment" may include but not be limited to: interviewing, physical examination, administering vaccines or other injections, minor surgical procedures, review of lab test, performing test and collecting specimens for outside labs to test. If you are the parent or guardian of a minor child, you affirm that there are no court orders now in effect that prohibit you from signing this document. You are providing consent to Integrative Family Medicine, PA and authorize medical treatment as indicated by Dr. Simone L. Norris. You understand that Integrative Family Medicine, PA will explain condition(s), foreseeable risks, and methods of treatment before treatment is provided. You authorize Integrative Family Medicine, PA to perform any additional or different treatment that is thought necessary if, in an emergency situation, a condition is discovered that was not known previously. By initialing here, you are consenting that you have carefully read and fully understand the Patient Consent for Treat and have had the opportunity to discuss your condition, concerns, and the above procedure(s) with the care provider.* _____

Payment Policy: *By initialing here you understand full payment for services rendered are due and expected to be paid in full at the time of your visit. It is your responsibility to file for reimbursement from your medical insurance carrier (except Medicare patients – seen by private contract only). For your convenience we accept cash, checks, debit cards or credit cards.* ***We do not accept American Express****.*: _____

E-Communication*: In order to facilitate communication, we may use e-mail communication with your permission. Be aware that we are dedicated to protecting your privacy. We use secure email for notification of upcoming appointment times. By initialing here you are authorizing us to communication with you via e-mail.*: _____

HIPPA/Privacy Practice Acknowledgement: *We will protect your private health care information and not share it with unauthorized parties without your permission. We may use your information for treatment, payment, or healthcare operations. The entire detailed HIPPA statement is available for your review and you may request a copy for your records. By initialing here, you acknowledge that Integrative Family Medicine, PA has provided you with a written copy of his/her Notice of Privacy Practices and have been afforded the opportunity to read the Notice of Privacy Practices and ask questions.* _____

Patient/Guardian Signature: _____ Date: _____

Treating Provider Signature: _____ Date: _____